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The Role of Middle Managers in the NHS: The Possibilities for Enhanced Influence in Strategic Change

Volume I

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Transcript Codes

Italics are used for tape-recorded interview material

All tape-recorded materials are verbatim transcriptions

... words, phrases or sentences of the extract omitted

[ ] information added to make the context and/or meaning clear

Data have been edited in order to preserve respondent anonymity.

All names are pseudonyms.

Abbreviations

A and E - Accident and Emergency Department

BPR - Business Process Re-engineering

CCHT - City Community Health Trust (pseudonym)

DHSS - Department of Health and Social Security

DoH - Department of Health

GP - General Practitioner

HR - Human Resource

HRM - Human Resource Management

IIP - Investors in People

NHS - National Health Service

NHSME - National Health Service Management Executive

NPM - New Public Management

SBU - Strategic Business Unit

TQM - Total Quality Management

WfP - Working for Patients

WIN Project - Welcoming, Informative, Non-Institutional Project

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ABSTRACT

This thesis concems the role of middle managers in strategic change in the NHS. It addresses a research gap identified by Dopson and Stewart (1990) who called for more empirical studies of the role of middle managers in specific contexts and highlighted the public sector as being of particular interest. It reports qualitative research carried out across 5 successive case studies in the NHS.

The contextual backdrop to the study is one of competing tensions around the role of the middle manager, both generally in organisations and specifically in NHS tmsts. On the one hand, it is argued that the role of the middle manager is one of diminishing importance. On the other, it is argued that the role of middle managers is one that should be enhanced. Both sets of commentaries tend towards the speculative and lack an empirical foundation. In the NHS such tensions are reflected in government policy. An enhanced middle manager role is encouraged through the development of a general management ethos. Simultaneously there have been attacks upon middle managers from the Minister for Health in the past Conservative Government and the present Labour Government.

Theoretically, a typology of involvement of middle managers upon strategic change developed by Floyd and Wooldridge (1992, 1994, 1997) is brought to bear as a conceptual lens with which to view the role of middle managers in strategic change in the NHS. Using this typology the role of middle managers is found mainly to be with the implementation of strategic change, rather than other roles, such as 'synthesising information', 'facilitating adaptability' or 'championing alternatives', although there are some illustrations of a role for middle managers beyond implementation of strategy.

Despite their main role remaining within the implementation of deliberate strategy, the case studies illustrate that there is a possibility for an enhanced middle manager role in strategic change within this. However, Floyd and Wooldridge's typology does not sufficiently distinguish between the differing influence that middle managers may enjoy within the implementation of deliberate strategy. Therefore, one suggestion is that further constmcts for the influence of middle managers upon strategic change be developed.

It is also noted that middle managers operate under significant constraints that impact upon the possibility of taking up an enhanced role, within the implementation of deliberate strategy and in roles outside this. Principal amongst these constraints is the presence of significant medical group power and the influence of central government intervention. Therefore, middle managers influence may be limited, on the one hand, to that which converges with the strategy set out by executive management that in turn has been driven by government prescription. On the other, it is likely to be limited mainly to that of the administrative domain rather than the medical domain or where influence is exerted upon the medical domain to changes with which the medical group is agreeable.

The empirical findings also illustrate that any enhanced role for middle managers, within the constraints of government policy and medical group power, may require the presence of certain conditions. Firstly, where strategic change allows for emergence as well as deliberateness, then middle manager may exert more influence upon strategic change. Secondly, they may exert more influence upon strategic change, where it is not solely conceived in top-down rational planning terms, but where is combined with a political element of strategic change. As a result the formulation and implementation of strategic change are likely to be intertwined rather than separate and sequential. This may allow for more involvement of middle managers in the strategic change process. Finally, in order that middle managers can take up the potential for an enhanced role under these conditions, there may need to be some investment in organisation and management development and organisational stmctures that facilitate boundary-spanning opportunities for middle managers.

INTRODUCTION

The Initial Research Interest

This thesis developed fi-om the researcher's interest in the role of middle managers in the NHS, which had developed during a 'life', prior to being an academic, as a Management Development Advisor at West Birmingham Health Authority 1989 to 1991. During this period of work the author observed that middle managers were subject to a role change. Rather than being professionals who, alongside their direct patient care, had to manage more junior members of their profession, middle managers were re-constituted as general managers with a professional background. In this role, they managed a wider range of staff outside their profession and were unlikely to engage in much direct patient contact. In developing and delivering management development, the author was part of the 'vanguard' of attempts by executive management to facilitate this role change for people such as nurse managers. However, there was substantial resistance to attempts to develop a general management ethos amongst this cadre of middle managers.

Initially the researcher explored such resistance to management development interventions through the vehicle of a dissertation as part fulfilment of an MSc. Personnel and Business Management, undertaken on a part-time basis at the University of Aston (1989-1991). The theoretical lens brought to bear in this work was Mintzberg's work on configurations (Mintzberg, 1979). The conclusion reached was that machine bureaucracy or adhocracy stmctures, combined with forces for efficiency and/or irmovation, rather than a professional stmcture combined with a

force for proficiency, were more likely to facilitate a successful management development intervention. This was published in a relatively minor journal, *Health Manpower Management* (Currie, 1993) and in such a way an academic career and a more serious interest in research began.

The opportunity to pick up this thread of research presented itself early in 1995 when the author of this thesis embarked upon a PhD programme.

Methodology

The methodology adopted to further investigate the interest developed by the researcher, during his time as a Management Development Advisor, was a qualitative one, which gathered data in five successive case studies - competence-based management development at Florence Hospital, business planning at Florence Hospital, marketing at Florence Hospital, human resource strategy at City Community Health Tmst (CCHT) and human resource strategy at Edwards Hospital. The main research tool was the semi-stmctured interview, of which 69 were carried out across Florence Hospital in three distinct phases, 20 were carried out at CCHT and 20 were carried out at Edwards Hospital. In Florence Hospital the interviews were interspersed by periods of observation over the two-year period (1995 -1997). In addition relevant documentation was collected in connection with each case study.

The research process was an inductive one in which the research themes connected to the question of the role of middle managers in strategic change were generated in the first three case studies at Florence Hospital and there was an iterative process of

reviewing relevant literature, gathering and analysing data. The themes developed through the first three case studies were subsequently taken forward to the cases of HR strategy at CCHT and then HR strategy at Edwards Hospital.

This is illustrated in the interview schedules, which are documented in appendices A to E. In the first phase of interviewing at Florence Hospital (appendix A), questions were more general - for example feelings and responses of middle managers to policy changes since 1983 - although specific questions were included about middle managers' resistance to the competence-based management development programme they were asked to participate in. In the second and third phases of interviewing at Florence Hospital (appendices B and C), more specific questions were asked about middle managers' influence upon strategic change via business planning and marketing activity and the researcher investigated a developing theme of constraints to the influence of middle managers in these areas. In particular questions were asked abaout the impact of central government intervention and medical group power upon middle managers' roles. Such constraints upon middle managers' roles and an ongoing focus upon the influence of middle managers in strategic change were taken forward as themes to the fourth and fifth case studies and questions asked to elicit data relating to this (appendices D and E). Alongside these questions, others were asked to gather data about constraining or inhibiting features of inner context, such as the characteristics of strategic change, organisational strcutures and investment in management education, which the earlier three cases had also suggested might be important variables in considering the possibility of an enhanced role for middle managers (also see appendices D and E).

The inductive way in which the research question was developed and a contribution to academic literature made, is also illustrated by a description of the research joumey during this study.

The Research Journey

In the early stages of the PhD the author negotiated access to the Florence Hospital in order to investigate the planning and delivery of a competence-based management development programme aimed at middle managers. Observation of the management development programme illustrated that middle managers could resist the imposition of a programme that was underpinned by generic competences. This reflected the earlier experiences of the researcher as a Management Development Advisor at West Birmingham Health Authority. It also became evident during the early periods of observation in Florence Hospital, which included work-shadowing and attendance at directorate meetings, and in general questions asked in the first phase of interviews, that middle managers might have an influence upon strategic change in ways other than merely resisting the imposition of deliberate strategy. These thoughts were taken forward to other case studies in a process of successive case studies (Eisenhardt, 1989), as described in the last section.

Business planning and marketing were areas, which appeared to be important part of strategy in Florence Hospital and middle managers used illustrations of business planning and marketing activity in early interviews when discussing their feelings about policy change and the organisational changes that were a result of pohcy. The researcher, judged business planning and marketing to be useful case studies for

further research and at this point adopted the conceptual lens provided by Floyd and Wooldridge (1992, 1994, 1997) to investigate the role of middle managers in strategic change in the NHS. This suggested that middle managers may take on roles beyond the implementation of deliberate strategy, which result in upward influence for middle managers (synthesising information) upon strategic change or influences strategic change upwards (championing alternatives) or downwards (facilitating adaptability) so that it diverges fi^om corporate strategy.

While, there were some illustrations of other roles in the cases of business planning and marketing, the main influence of middle managers lay within the implementation of deliberate strategy. In these cases constraints upon middle manager influence were clearly apparent. In particular, the vagaries of central government policy and medical group power limited the opportunities for an enhanced middle manager role in strategic change. However, to some extent, in some more commercially sensitive areas, such as Surgical Services, it appeared that these constraining influences could be mediated by providing boundary-spanning opportunities for middle managers and by investing in individual middle manager development.

In this way, the research question developed towards the title of this thesis - 'The Role of Middle Managers in the NHS - The Possibilities for Enhanced Influence in Strategic Change'.

These issues - the role of the middle managers in strategic change, the constraints upon their influence and conditions that might facilitate an enhanced role - were taken forward to a fourth successive case, human resource strategy at City

Community Health Tmst (CCHT), which the researcher judged might illuminate the developing research question further. This case added a further theme related to the research question - that of the characteristics of strategic change and how they impacted upon opportunities for an enhanced role for middle managers. Where strategic change reflected private sector practice, where it was imposed top-down and where means and ends were highly prescribed by the corporate centre, then middle managers' role was limited to that of mere resistance and in some cases, not even that.

Finally, a fifth case study was undertaken, human resource strategy at Edwards Hospital, to further elaborate the research question. This provided further illustration that the main role of middle managers lay within implementing deliberate strategy but also fiirther showed that they could enjoy enhanced influence in this role, thus questioning whether the typology of involvement of middle managers in strategic change (Floyd and Wooldridge, 1992, 1994, 1997) allowed for this. The final case also illustrated further the presence of constraints upon middle manager influence, particularly the impact of central government policy. It also suggested that certain characteristics of an organisation's inner context might facilitate an enhanced role for middle managers - where emergent strategic change was allowed for, where organisation stmcture allowed boundary-spanning opportunities for middle managers and where there was investment in management education for middle managers.

Structure of Thesis

In order to address the question of the role and influence of middle managers in the NHS and the necessary conditions for enhanced influence, the thesis is set out as follows.

The first three chapters set out the literature that relates to the issue under investigation. This draws upon three fairly distinctive areas of literature. Firstly, there is a body of relevant literature commenting generally upon the experiences of middle managers in organisations. Secondly, there is literature in the strategic management area, which is relevant to discussion of the role of middle managers in strategic change in the public sector context. Thirdly, there is a body of literature that discusses government policy towards the NHS and the development of general management in the NHS. Within this there is cormnentary upon the role of the middle manager in the NHS, which is particularly pertinent to the research question in this thesis.

Following the principle that one should move from the general to the specific in the literature review, the first three chapters are set out in the following order.

Chapter 1 sets out the debate in the literature about whether middle managers should view their future with pessimism or optimism with respect to their future role in organisations.

Chapter 2 reviews what the relevant strategic management literature suggests about their future role. In the first part of this chapter, characteristics of strategic change

which inhibit or facilitate an enhanced role for middle managers in strategic change, beyond the implementation of deliberate strategy, are examined. In particular, the balance between top-down rational planning and deliberate strategic change, which the Classical School of thinking about strategic change advocates (Whittington, 1993) and more emergent strategic change which the Processual School advocates (Whittington, 1993), is discussed. In the second part of this chapter, a framework for describing any enhanced middle manager role is set out (Floyd and Wooldridge, 1992, 1994, 1997) and fiirther conditions necessary for an enhanced role identified.

In chapter 3, the debate about the future of middle managers and the characteristics of strategic change that may contribute to an enhanced role for middle managers, are considered specifically within the NHS. Certain distinctive features of the NHS, which have a bearing upon the middle manager role, are revealed here. For example, medical group power and the relationship between central government and NHS tmsts are highlighted as important influences upon the potential for an enhanced role for middle managers.

The conclusion reached, from the review of relevant literature in chapter 1, is one that notes two tendencies, which appear to be oppositional. Firstly, there is a tendency to attack and de-layer middle managers. Secondly, there is a tendency to constitute middle managers as necessary change agents for corporate transformation. Chapter 2, in particular, suggests that middle managers can and should enjoy an enhanced role in strategic change. This is more likely where, for example, strategic change is emergent as well as deliberate and where formulation of strategic change is intertwined with implementation. Therefore, top-down rational planning may need to be complemented

by, for example, a political element of strategic change. This is particularly important in public sector organisations in which there is a powerful professional group, such as the medical one. In addition, issues of organisational stmcture and organisation and management development are highlighted as important influences upon any possibility for an enhanced middle manager role.

The NHS literature discussed in chapter 3 suggests, on one hand that middle managers are likely to enjoy an enhanced role in strategic change as a result of the promotion of a general management ethos through policy reforms in the 1980s and 1990s. On the other hand, in relation to the possibility for an enhanced middle manager role in the NHS, the literature revealed in chapter 3 suggests that there are some significant issues that affect whether middle managers are likely to take up an enhanced role in the NHS. Besides the issue of how strategic change is conceptualised, there are other conditions under which strategic change is realised that are distinctive to public sector contexts such as the NHS. Firstly, the relationship between the government at national, regional and district levels and individual NHS tmsts is important influence upon the middle manager role. Secondly, the presence of a powerful medical group may significantly constrain the realisation of an enhanced role for middle managers. Thirdly, generic transfer of organisational and managerial practices from private to public sectors may complement top-down rational planning and further exclude middle managers from the strategic change process because their knowledge of operational context is not brought to bear upon formation of strategic change. Further, recently, there has been goverrunent pressure to cut management costs in the NHS. Therefore, there also appear to be two oppositional tendencies in the NHS as to the future role of middle managers in strategic change. In the NHS, as in organisations

generally, the question of whether middle managers enjoy an enhanced role in strategic change or whether their role has been reduced remains unanswered.

However, before the data is discussed in chapters 5 to 8, in chapter 4, the methodology is set out. The account, which is represented in the empirical chapters that follow, is recognised as being socially constmcted in the interaction of the researcher with subjects in the cases. Therefore, in this chapter the researcher is situated in the account produced of strategic change.

Chapters 5 to 8 represent the data gathered in the cases. In chapter 5, the case of business planning at Florence Hospital is examined. In chapter 6, the case of marketing at Florence Hospital is examined. Chapters 7 and 8 both examine the realisation of human resource strategy, the first at CCHT and the second at Edwards Hospital.

The representation of the data in each of the empirical chapters is preceded by a discussion of the policy background and the literature that relates to the intervention being considered. For example, in chapter 5, the data about business planning is preceded by a discussion of the literature that examines the implementation of business planning in health care contexts and the policy background to this. Similarly in chapter 6, a much greater volume of literature that exists around attempts to increase the marketing orientation in the NHS is discussed. In both cases, the relevant features of organisational context are described and the main stakeholders identified. In each case, given that the problem of identification of the middle manager was raised in chapter 1, the middle manager is defined (also see section 4.3.1(b)(i) ' 'Who

are the middle managers?'). Chapter 7, as well as setting out the relevant characteristics of the inner context of CCHT, sets out the policy background to human resource strategy. It also discusses an important issue in this thesis, the relationship between the corporate centre and the operational periphery, by examining the literature on the role of the Personnel function in the NHS. This issue is also relevant to chapter 8. The data presented in chapter 8 is preceded by a description of the relevant features of Edwards Hospital's inner context. Chapter 9 in conclusion provides a summary of the findings, assesses whether they are applicable to other settings, suggests areas for future research and finally, sets out the contribution of the PhD.

Contribution of PhD

The debate about the role of middle managers in organisations remains relatively ill-informed by empirical evidence about the role of middle managers in strategic change (Dopson and Stewart, 1990). Both generally in organisations and in the NHS specifically, there remains a lack of empirical studies to back up arguments about the role of middle managers in strategic change. This thesis seeks to address this problem and provide empirical illustration of an enhanced role (or not) for middle managers in strategic change.

The data in the four empirical chapters provide illustrations of the themes that emerged in relation to this main research question about the role of middle managers in strategic change. There are some illustrations in the case studies that such enhanced influence may involve a role beyond the implementation of deliberate strategy.

However, much of their enhanced influence lies with additional discretion allowed to middle managers within the role of implementing deliberate strategy in which they decide the means to meet broad ends set out by executive management.

That any influence remains within the role of implementing deliberate strategy is largely due to constraints imposed that emanate from the outer context of the tmsts studied, notably that of medical group power and that of central government intervention.

Any enhanced influence within the role of implementing deliberate strategy or to a limited extent in other roles is dependent upon certain conditions. Of particular interest is the impact, upon the role of middle managers, of the balance between deliberate and emergent strategy, the balance between top-down rational planning and political elements of change and the separation of formulation and implementation of strategic change. Where strategic change allows for emergence, then middle managers appear likely to enjoy an enhanced role in the process. The importance of organisation stmcture is also illustrated by the empirical findings. In particular, where there are boundary-spanning opportunities for middle managers then they may be more likely to enjoy an enhanced role in strategic change. In addition, the development of the capacity of middle managers for change may allow them to take up an enhanced role in strategic change.

In summary, firstly, this thesis operationalises the process of successive case studies (Eisenhardt, 1989). More importantly, secondly, the thesis contributes to generic management literature by giving assertions about the role of middle managers an

empirical basis. If the debate is constructed in an oppositional way between those pessimistic and optimistic assertions about their future, then this thesis adds more weight to the latter than the former. The thesis supports more optimistic assertions but recognises considerable constraints to an enhanced role, at least within the NHS. Thirdly, in a contribution to the health services management literature, the study considers the limiting features within the context of the NHS to any enhanced influence for middle managers and how features of irmer context might facilitate an enhanced role for middle managers. Finally, in a fiirther contribution to generic management literature it assesses the utility of the typology developed by Floyd and Wooldridge (1992, 1994, 1997) and suggests that there is scope for its fiirther development to distinguish between the differing influence middle managers might enjoy in a role of implementing deliberate strategy.

Chapter 1

The Experiences of Middle Managers in Organisations

1.1 Introduction

In this chapter the backdrop to the study will be outlined. This will consider the experiences of middle managers in organisations in the 20th century, discussing forces that influenced their numbers and their role in organisations. Given the pre-eminence of academics in the USA in the area of strategic management, literature relating to the experience of middle managers in the USA will be considered alongside academic commentary specifically about the experiences of middle managers in the UK.

The literature relating to the different geographical contexts suggests globally convergent forces to be at work. Firstly, the period for growth in middle manager numbers from the start of the century to the 1970s will be described - what has been labeled a 'golden age' (Wheatley, 1992). Following this, the experience of middle managers in organisations in more recent years (1980s onwards) will be described and analysed. In considering the experiences of middle managers in recent years, some commentators are pessimistic and some commentators are optimistic. The pessimistic view emphasises the trend towards de-layering and a reduced role for middle managers in organisations. The optimistic view emphasises the re-shaping and enhancement of the middle manager's role in corporate re-regeneration. At the end of

this chapter, these two commentaries, which appear contrasting, are fiirther discussed. From this, the research gap towards which the thesis will contribute, is identified.

1.1.1 Definition

Before entering into discussion of the experiences of middle managers in organisations this century, let us define what is meant by this term. This is necessary in the face of criticism that debate about the future of middle management is compromised because the middle management level as a unit of analysis remains poorly dehneated (Tumbull, 1998). As a result, care needs to be taken with the definition of middle managers (Dopson and Stewart, 1990, 1993). Middle managers do not form a well-defined homogenous group that can be differentiated easily fi-om executive managers and fi-om first line managers. This has resulted in academic studies considering a broad spectmm of managers in organisations, who may include more junior and senior managers as well as middle managers, yet making judgements upon the role of the middle manager specifically (Pinsonneault and Kraemer, 1993).

In this thesis, middle managers are those who perform a co-ordinating role where they 'mediate, negotiate, and interpret connections between the organisation's institutional (strategic) and technical (operational) levels' (Floyd and Wooldridge, 1997: 466). Put differently, middle managers link vertically related groups (Pugh et al. 1968). Specifically, within this definition, middle level managers are 'employees who have at least two hierarchical levels under them' (Staehle and Schirmer, 1992: 70).

A further distinction is necessary between those middle managers that work within specialist functions such as marketing and human resources and those managers who work within operations but also perform the co-ordinating role. Important in this distinction is the concept of boundary-spanning where organisation - environment transactions are managed. For example, in specialist functions such as marketing, middle managers are more likely to take up boundary-spanning roles while those middle managers in operations are likely to be intemally focused and are non-boundary-sparming (Floyd and Wooldridge, 1997). An additional distinction between the two is those middle managers in functions such as marketing and human resources may seek to manage the contribution of those middle managers in operations.

This study will focus upon those latter middle managers in operations. This study considers managers in areas such as marketing and human resources as positioned within the corporate centre. As such they are viewed in executive management in this thesis. The definition of middle managers in this thesis, which focuses upon those in operations, corresponds with that taken by Smith (1997) who defined middle managers as those, *'within* divisions, directly involved in planning and co-ordinating the production of services that are specific to their own units'' (Smith, 1997:23).

1.2 A Period of Growth in Middle Manaeers

In considering the period of growth for middle managers, it is worth noting that academic commentators suggest similar trends in the USA and UK. For example, in the USA the growth of organisations was predicated upon hiring 'dozens and

sometimes hundreds of lower and middle managers' (Chandler, 1977: 411). Jacoby (1984) notes a steady increase in the ratio of administrative to production employees between 1880 and 1920 in the USA as a resuh of the creation of a new stmcture of management, which included middle managers, a trend that continued as the numbers of managerial and supervisory employees increased disproportionately throughout the twentieth century (Melman, 1951, Bendix, 1956). As a result of this, the ranks of middle managers grew fivefold between 1950 and 1975 in the USA. By 1980, it is estimated that middle managers made up ten per cent of the US workforce. The number of organisational layers multiplied so that it reached more than 100 at some large US firms (Frohman and Johnson, 1993).

They were the message carriers. Their roles and responsibilities were supervisory, controlling the vertical flow of directions and information within departmental charmels. They compiled data and prepared reports for those at the top. Middle managers, during this period, appeared to be 'riding high' (Frohman and Johnson, *ibid.):*

> For the better part of the twentieth century, middle level managers in decentralised bureaucratic stmctures have had a unique role in the firm. Not solely constrained by shop floor production politics, they possessed greater managerial latitude than the foreman of the nineteenth-century drive system of management. But neither were they constrained by top management (Smith, 1997: 19).

There was a similar trend in the UK. In providing a report for the British Institute of Management, Wheatley (1992) describes a 'golden age' for middle managers that lasted until the seventies:

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[1] In this study, in the NHS, the concern is with those managers directly involved in planning and co-ordinating the production of services that are specific to their own *directorates,* in the case of hospital trusts, and *localities,* in the case of community trusts, rather than *units.*

'Tum the clock back forty or fifty years ... Organisations were far more dependent on the span of control of individuals than they are today, with broad bureaucratic pyramids rising upwards in a constant ratio of manager to managed. Tiers of management provided the only mechanism through which information could flow upwards and decisions downwards. As an organisation grew, in terms of the value-adding producers at the bottom of the pyramid, so did the need for layers of management above them. Join a growing company and promotion was virtually assured ... hiccups apart, the period from 1960 to the mid-70s were generally good years. (Wheatley, 1992: 5).

1.3 Grounds for Pessimism

The 'golden age' for middle managers was to end during the seventies. Deregulation, global competition and pressure for short term results created a 'new competitive reality' that permanently altered the rules of the ball game in the USA and UK (Daudi et al, 1997; Frohman and Johnson, 1993; Giddens, 1990; Hirst and Thompson, 1995; Robertson, 1992). Such forces were coupled with advice fi-om popular business books and journals to 'cut out the fat', to get 'lean and mean', which meant that senior executives found the lure of downsizing to be irresistible (Cascio, 1993). Downsizing, the plarmed elimination of positions or jobs, is a phenomenon that has affected hundreds of companies and milhons of workers since the late 1980s. Typical of the popular management literature to which senior executives were exposed (Dmcker, 1988; Peters 1987, 1992; Peters and Waterman, 1982), *In Search of Excellence* (Peters and Waterman, 1982), for example, urged that 'leaner' decentralised work environments should replace bureaucratic and centralised organisational stmctures. Such exhortations remained into the 1990s and were evident in the USA and the UK. The experience of organisations in the USA was one that led one academic to comment, 'it's hard to pick up a newspaper on any given day and not read about

another well known organisation that is announcing a corporate restmcturing' (Cascio, 1993: 95).

A particular characteristic of downsizing in the USA was that it had a decidedly white-collar pattern to it, with relatively more middle managers eliminated during the downtum. In all sectors in the USA corporate leaders were streamlining their firms to become more competitive and profitable by aggressively attacking their corporate staffs and operations managers in the effort to reduce administrative overhead in the face of the economic climate (Smith, 1997) (see section 1.3.1 for figures to substantiate this).

Middle managers remained targets for blame for the contemporary decline in American productivity and competitiveness in the 1990s (for example, Heckscher, 1995 and Smith, 1997, comment on this continuing negative perception of middle managers). This is a reflection of a perception that they subtract rather than add value to organisations and are hesitant to irmovate and take risks:

' The traditional manager was a link in a reporting chain - a gatekeeper to ensure that things stayed within bounds; an interpreter to the troops below of the sentiments of those above and a message carrier to higher levels. Did middle managers add value? In too many cases, as administrators they subtracted value rather than added it, by taking extra time, by telling eager subordinates that the upper echelons would never approve their proposals, by dampening enthusiasm and direct access' (Kanter, 1989: 94)[2].

Many took more extreme views. For example, Peters (1992) stated:

[2] Ranter's work suggests there are two types of middle manager - those who subtracted value and those who were 'changemasters'. The implicit assumption in her work, in spite of criticism of those former middle managers, is that the organisation should recognise the importance of the latter as purveyors of change

'Middle management, as we have known it since the railroads invented it right after the Civil War, is dead. Therefore, middle managers as we have known them, are cooked geese' (Peters, 1992: 758).

Peters *{ibid.)* goes on:

'Middle management ... is dead ... It's over, d'ya hear? Over. Over. Over' (Peters, 1992: 758).

These trends were also evident in Europe (Daudi et al, 1997; Staehle and Schirmer, 1992) and specifically in the UK (Wheatley, 1992). Burrell (1996), for example, in describing the UK experience of re-stmcturing, asserted that, 'middle management are perceived to be the corporate turkeys; anti-democratic, anti-change and ripe for culling' (Burrell, 1996: 60). In a study of middle managers in the UK, Wheatley (1992) describes three forces impacting upon middle management in the UK in the 1980s that fuelled this negative view of the value of middle managers. Firstly, the flavour of corporatism started to change from a military hierarchy model to one of individual profit centres, their managers deciding what needs to be done to make those profits. One of the sources of those profits was the removal of layers of management no longer regarded as necessary. The second key factor was the need to achieve sharp and sudden cost reductions in the face of a recession. Thus typically a company would seek ways to shrink and condense its management fimctions. In this, the third and final influencing factors of the '80s, information technology, which replaced the information gathering and dissemination role of the middle manager, aided them.

Such forces, as in the USA, led to pessimistic predictions in popular management literature for the future of middle level managers in the UK (For example, Caulkin,

1995; Lester, 1992; Gates, 1992). In his report for the British Institute of Management, Wheatley (1992) commented that:

'Even the term 'middle management' is vaguely pejorative. If directors can be said to have arrived, and senior managers to be well on the way, the all too prevalent suspicion is that middle managers are bogged down somewhere en route' (Wheatley, 1992: 5).

Some commentators portrayed middle level managers as being in decline. In considering this, much of the literature focuses upon the responses of middle managers to the introduction of information technology (particularly, Wheatley, 1992) and a de-layering of middle level managers following organisational rationalisation (Dopson and Stewart, 1990). Studies of middle management have suggested that there is growing disillusionment and disaffection amongst middle managers (Johnson and Frohman, 1989; Snell and Davies, 1988) with talk of 'bumout', 'professional suicide' and 'mid-career crisis' (Hunt, 1986); the 'managerial menopause' (Hunt, 1982; Davies and Deighan, 1986); and the 'reluctant manager' (Goffee and Scase, 1992; Scase and Goffee, 1989). As well as above there are studies by - Brockner, Tyler and Cooper-Schneider, 1992; Doherty, Bank and Vinnicombe, 1995; Guest and Peccei, 1992; Newell and Dopson, 1996; Noer, 1993; Thomas and Dunkerley, 1999; Thomhill and Gibbons, 1995; Thomhill and Saunders, 1997 - to name but a few of the studies examining the 'survivor syndrome'. However, it is not upon the 'emotional' impact upon middle managers of re-stmcturing that this thesis wishes to focus. This ground is well-covered.

In contrast, this thesis is concemed less with the response of middle managers to change and more with their roles following such changes. In particular, in this

contextual chapter, it is concemed with downsizing and the subsequent de-layering of middle managers that may lead to changing roles for middle managers, declining or otherwise.

Before going on to discuss this fiirther, it is worth briefly saying something about the impact of IT, since this is perceived as a cause of the decline of the middle manager by some academic commentators (Dmcker, 1988; Hicks,1971; Hoos, 1960; Simon, 1960; Wheatley, 1992). However, there is a significant body academic literature that suggests otherwise (Buchanan and McCalman, 1988; Dopson and Stewart, 1993; Kanter, 1982; Millman and Hardwick, 1987; Nonaka, 1988). Dopson and Stewart (1993) provide a useful overview of this debate, which also suggests the impact of IT upon the role of the middle manager, has been over-emphasised. Instead of being a cause of decline, a high level of IT in an organisation may merely be an enabler of organisational downsizing. Even here, the middle manager role is likely to be supplanted only where there is a high degree of centralisation of decision-making in the organisation (Pinsonneault and Kraemer, 1993)[3]. Therefore discussion turns to the trend of downsizing of organisations and the subsequent delayering of the middle manager level as a cause of their decline, rather than the impact of IT upon middle managers.

1.3.1 De-layering

American business appears to be firmly committed to cutting the administrative layers staffed principally by middle management (Osterman, 1986). Overall, these cutbacks

[3] A research project funded by CIMA, which the researcher leads, examining the interaction of middle managers and strategic change in the area of MIS/IT in the NHS, also suggests this.

in the ranks and employment conditions of middle management are part of a larger permanent shift in the American employment framework (Smith, 1997). While all levels of the hierarchy are affected, it is the middle managers jobs which took the bmnt of the job losses, hence the use of the term 'de-layering'.

In the USA, Peters (1985, cited in Smith, 1997) cites the example of Dana Corporation's cut of corporate staff from 600 to 85 and from 15 to 5 layers of management and the Bmnswick Corporation's cut from 600 to 200 corporate staff members. Supporting this and suggesting the trend continues into the 1990s, another study claims that middle managers accounted for 19 per cent of job losses between 1988 and 1993 yet only comprised 8 per cent of the US workforce (Heckscher, 1995). Certainly, recent patterns of employment suggest that middle managers have become one of the most vulnerable groups to job loss and job insecurity (Cameron et al, 1991; Cascio, 1993). From 1979 to 1987 the numbers of middle managers and professional staff in US companies were cut by 1 million and between 1987 and 1991 75 per cent of the Fortune 1000 companies are reported to have reduced their numbers of middle managers (Frohman and Johnson, 1993). Other studies estimated that 85 per cent of the Fortune 1000 companies 'downsized' their workforce between 1987 and 1991, affecting more than 5 million jobs (Cameron et al 1991) in the purge. Yet another study claims that, in the USA, while middle managers make up only 5 to 8 percent of the workforce, they accounted for 17 percent of all dismissals from 1989 to 1991 and that each year for the past 3 years (1989 - 1991) between 1 million and 2 million middle managers were laid off (Cascio, 1993).

Admittedly distinguishing between the changes in the numbers of managers at different levels is problematic (Dopson and Stewart, 1990) but it appears to be a trend that is mirrored globally. In a European study of middle managers, for instance, 'the recent European wide recession and its continuing reverberations have meant that for many 'de-layering', 'downsizing' or 'rightsizing' is a reality and they have to cope with this bmtality directly' (Daudi et al, 1997: 4). Specifically in the UK, Wheatley's (1992) survey for the British Institute of Management found 'the evidence for de-layering as overwhelming' (Wheatley, 1992: 15). In this survey some 80 per cent of managers had experienced one or more restmcturing programmes over a period of 5 years prior to the survey. Wheatley *{ibid.)* further suggests that because, in the service and government sectors, there are a disproportionate number of middle managers that the effects of de-layering will continue to be felt more severely by those managers in these sectors. More recently, in a UK study across 50 organisations in the private, public and voluntary sectors, Thomas and Dunkerley (1997, 1999), found middle managers in diverse contexts were experiencing flatter stmctures, de-layering and the consequential increased spans of control.

Supporting evidence for this are some well publicised cases of de-layering of middle managers which suggest a greater decline in their numbers than Dopson and Stewart (1990, 1993) suggest. One example was the case of the National and Provincial Building Society where de-layering resulted in the redundancy of a group of district managers (Wood, 1990). Yet another example was branch 'satellite-ing' at Nationwide-Anglia (Jacobs and Bolton, 1993), where in the wake of the merger branch managers, traditionally responsible for single branches, were increasingly assigned multi-branch responsibilities. These may or may not be the tip of a growing

iceberg. On one hand, all over the country, it may be that middle managers are being quietly laid-off, a couple here, or a dozen there from thousands of companies of all sizes and sectors (Wheatley, 1992). On the other hand, they may merely represent highly publicised case studies that lead commentators to suggest that de-layering goes across all sectors in the UK without any empirical foundation for this assertion.

In support of more pessimistic commentary, some argue that even the relatively limited traditional role of middle managers as strategy implementers is disappearing as a result of new management philosophies and notions such as TQM and autonomous work teams (Bomcki and Byosiere, 1991; Bomcki et al, 1992; Schuler and Harris, 1992; Sherwood, 1988; Walton and Lawrence, 1985; Wheatley, 1992). For example, a study of TQM by Schuler and Harris (1992) in the USA argued middle managers roles would be undermined as a result of its implementation because it would supplant their traditional role in implementing and monitoring the instmctions of executive management. Other USA studies have shown that the implementation of semi-autonomous work groups leads in many cases to the elimination of middle levels of managerial workers (Walton and Lawrence, 1985; Sherwood, 1988).

In the UK, middle managers themselves expect TQM to have the biggest single impact upon their roles (Wheatiey, 1992). This begs the question, 'given middle management's predominantly troubleshooting role, will middle managers become redundant in a Total Quality environment?' (Wheatley, *ibid:* 26). The impact of new forms of organisation such as semi-autonomous working groups upon middle managers can also be seen in the UK - for example, in the case of the Inland

Revenue.'* Here the number of managers at the middle management level was drastically reduced and the level below this took up a team leader role (Procter and Currie, 1999). Others in the UK have grouped together the adoption of practices, such as HRM, BPR, culture management, as well as teamworking, and argued that, seen as a whole, they remove the need for layers of middle managers controlling and co-ordinating activities. This is because the adoption of these practices gives rise to self-control by workers through the intemalising of the corporate culture and by new forms of surveillance from developments in new technology (Thomas and Dunkerley, 1997, 1999).

1.4 The Optimists

However, the pessimistic view, that following de-layering the traditional role for middle management has been effectively eradicated, has been challenged on a number of grounds by some academics in the USA and the UK. Firstly, it is argued that the claimed benefits of downsizing haven't been delivered because costs retum. These retum either directly, for example, as ex-middle managers are employed as consultants or indirectly, because, 'large scale restmcturing decisions inevitably destroy part of an organisation's social network, and that this may explain why firms have experienced negative results from the restmcturing process' (Floyd and Wooldridge, 1997: 481). Implicit in this may be that de-layering of middle management should be questioned and perhaps, even that re-layering should commence.

[4] The author of this dissertation has been involved in a study of teamworking at the Inland Revenue. Here, the introduction of teamworking has been accompanied by a delayering of the middle management level in the organisation.

Secondly, some commentators have noted that there is circularity in approaches to many of the criticisms about middle management. Burrell (1996) sees attacks upon middle management as nothing new. He argues such attacks are linked to periods of economic recession: 'might it not be that, in times of economic recession, the blame for poor performance might be laid at the doors of expert functionaries rather than their superiors?' (Burrell, 1996: 62). In support of this, Smith (1997) commented that:

'Corporate top management have all too willingly scapegoated middle management for alleged problems of hierarchy and rigidity. In the absence of persuasive scholarly evidence to the contrary, they will have full licence to continue to cut and degrade management, often at the expense of both managers and workers' (Smith, 1997: 197).

Thirdly, and most importantly in relation to the aims of this thesis, there is a body of empirical research on middle management in both the USA and UK which challenges suggestions that middle management is dead. This argument is based firstly, on questioning whether the number of middle managers has declined and secondly, whether the role of the middle manager has diminished.

Dopson and Stewart (1990), for instance, question whether claims of a decline in the number of middle level managers are accompanied by credible figures to back this up. Their own work suggests only a modest decline in the UK in the proportion of middle managers narrowly defined. However, there does appear to be some credible figures to show a relatively large decline in numbers of middle managers in the USA (see section 1.3.1), although figures that suggest a relatively large decline in middle managers do not appear to exist in the UK[5]. However, this thesis puts the issue aside of whether the decline in the number of middle managers has been relatively modest

[5] Dopson and Stewart (1990; 1993) draw upon the annual National Management Salary Survey conducted by Remuneration Economics to claim a modest decline in middle manager numbers.

or relatively large, compared to other employee groups, in the UK and signals that this question needs to be grounded via fiirther empirical research. Instead, this thesis concems itself with the question of whether the role of those remaining middle managers has been reduced or if, in contrast, it has been reshaped or even enhanced.

Besides questioning the claims of a relatively large decline in the number of middle managers in the UK, some commentators have also questioned claims that their role has been reduced. For example, Dopson and Stewart (1990), who undertook eight case studies in a diversity of organisations in the UK within a wider six country European study, argue that, 'middle managers now work in a more turbulent environment which has frequently radically changed their role and function' (Dopson and Stewart, 1990: 13). In particular they argue that - middle management jobs become more generalist with greater responsibilities and a wider range of tasks, middle managers are responsible for a wider range of staff, they are held more accountable for their work and a greater emphasis is put upon their performance, with performance being more visible due to IT. They concluded that the shorter hierarchy in most organisations means that middle managers are closer to executive management and the strategic and policy arena and that they have a clear area of responsibility with more control over the resources they need. Cmcial here is the suggestion that an enhanced role for middle managers might involve more input into the strategic and policy arena.

Others support the argument of Dopson and Stewart (1990). Staelhe and Schirmer (1992) argue in their comparative study across Europe that a discemible trend towards decentralisation in organisations results in a delegation of responsibility to lower and

middle-level managers, which enlarges their tasks and responsibilities. In particular, the devolvement of the HR function is seen to make the middle manager's role more demanding (Daudi et al, 1997; Keen and Vickerstaffe, 1997)[6]. Further, based upon the principle that involvement, participation, empowerment and ownership motivate people, there arose an expectation that middle managers, 'would rise to the challenge and enthusiastically accept their new responsibilities' (Johnson and Frohman, 1989: 107).

Many other studies recognise the impact of decentralisation upon middle managers and pick up on the notion of enlightened or empowered manager (Nonaka, 1988; Bomcki and Byosiere, 1991; Bomcki et al 1992; Frohman and Johnson, 1992; Nonaka et al 1992) or entrepreneurial managers (Millman and Hartwick, 1987). For example, the new discourses of management see the 'new manager' as one who is, 'entrepreneurial, irmovative, a good team leader' (Thomas and Dunkerley, 1997: 10). Frohman and Johnson (1993) go as far to state:

'The recovery in American competitiveness won't last without middle management on board. They hold the keys to the effort to manage the functional complexities of global operations, to maintain a line of state-of-the-art products, to shorten the time required in the new product cycle, and to offer products that meet world-class quality standards' (Frohman and Johnson, 1993: 17).

Therefore, others, alongside Dopson and Stewart (1990, 1993) also suggest that one of the main features of any enhanced role is that there are new responsibilities for middle managers and that these involve middle managers to a greater extent than they were previously in strategic change. For example, Nonaka and Takeuchi (1995)

[6] That there is decentralisation of HR responsibilities in particular is unsurprising since many best practice models of HRM stress the need for line managers to take back primary responsibility for the delivery of good people management, and many commentators see this development as a defining element of an HRM approach (see Beer et al, 1984; Storey, 1992).

suggest that the contribution of middle managers to strategic change is cmcial because they act as the 'strategic knot' that binds top management with front line managers. They work as a 'bridge' between the visionary ideals of executive management and the often-chaotic realities of business confronted by front line workers. In earlier work Nonaka (Nonaka, 1988) talked of 'compressive management' whereby executive management creates the vision but middle management creates and implements concrete concepts to solve and transcend the contradictions arising from gaps between what exists at the moment and what executive management hopes to create. Therefore, in this conception of the middle manager role, Nonaka (Nonaka, 1988; Nonaka and Takeuchi, 1995) suggest a more influential role for middle managers that goes beyond merely implementing deliberate strategy, which has been decided by executive management.

Despite concem that middle managers may subtract value in some cases (Kanter, 1989) (see section 1.3), Kanter (1982, 1983) suggested that middle managers may be able to take on a more influential role so that they become change agents in delivering the strategic goals of the organisation. She viewed middle managers, if empowered and irmovative, as America's most potent weapons in its battle against foreign competition. In her discussion of entrepreneurship, she sees middle managers using political skills to change and redirect organisational energies so that new strategies, products, markets, tumaround processes, stmctures and networks can be achieved. She states that a company's productivity will increasingly depend on the degree to which it allows its middle managers to be innovative and to combine ideas with action. Therefore, somewhat ironically in the face of reductions in the numbers of middle managers, organisational goals may be more, not less, dependent upon the

innovation, creativity and commitment of these same managers (Newell and Dopson, 1995; Daudi et al 1997; Smith, 1997). However, much of this literature about the middle manager as change agent is speculative. Kanter, for example, appears to argue both that middle managers subtract value from organisations (Kanter, 1989) and that they are cmcial in realising strategic change in organisations (Kanter, 1982, 1983). As a result, there is a need for more empirical evidence about the role of middle managers, particularly empirical evidence to illustrate the realisation of an enhanced role (see section 1.5).

1.4.1 Conditions For an Enhanced Middle Manager Role

The work of Frohman and Johnson (1993) represents one of the few studies that illustrates the realisation of a enhanced middle manager role empirically. They use illustrations from the case of General Electric in the USA to illustrate that middle managers are of cmcial importance in organisations. They also illustrate that a first phase of delayering middle managers has been followed by a second phase that seeks to enhance their role. From the mid-1980s onwards in General Electric thousands of middle managers were laid off However, even following drastic de-layering there still remained 100,000 middle managers at General Electric in 1991, representing one-third of total employment. As a result a second phase of strategic change has shifted the emphasis towards the development of capabilities of middle managers with the CEO, Jack Welch, personally involved in every programme aimed at the middle managers.

Similarly, Frohman and Johnson (1993) described how Procter & Gamble have recognised the importance of their middle managers in their efforts to be a world class competitor by restmcturing its approach to marketing its individual brands and giving middle managers control and responsibility for a group of products. Of relevance to the research question in these examples, is the question of the necessary conditions for an enhanced middle manager role. In the case of Procter and Gamble, as will be fiirther discussed in chapter 2, the restmcturing of the organisation allows middle managers to span boundaries within and outside the organisation. Of further relevance to the research question, in the case of General Electric, the Chief Executive recognised that one of the conditions for an enhanced role for middle managers may be that their individual capacity to change may need to be built up. This will also be elaborated upon in chapter 2 and chapter 8.

Others have also considered the necessary conditions for an enhanced role for middle managers. Some commentators, while arguing that middle managers have an important role in strategic change beyond implementing deliberate strategy, stress that organisational conditions may inhibit the realisation of the potential for an enhanced role for middle managers. For example, middle managers may become squeezed between the requirements of carrying out senior management strategy and the demands of the employees in their team, as well as experiencing job insecurity (Scase and Goffee, 1989). Therefore they may be unresponsive to both involvement in strategic change and the demands of employees. This may give rise to a 'gap in the middle' of organisations where:

'[The expectation by top managers] that middle-level individuals would rise to the occasion and enthusiastically take on their new responsibilities ... and attempts in

organisations to improve organisational effectiveness by giving more responsibility to people at middle levels are not working' (Johnson and Frohman, 1989: 107).

This may be because middle managers view decentralisation as illusory. For example, in their study of local government middle managers, Keen and Vickerstaffe (1997), found that the realisation of an enriched role for middle managers, following devolvement of HR responsibilities, was endangered by the increasing tendencies within the organisation towards recentralisation and the diminution of the middle managers levels of autonomy. Similarly, Redman et al (1997) found branch managers in building societies were restricted in their entrepreneurial activities by the reality of a 'pmdent' corporate culture, and the bureaucratic mles governing their decision-making. They found that the branch manager's operational world is much closer to non-entrepreneurial activities, aimed at high performance within routine job assignments, and that their physical isolation makes it difficult for them to engage in coalition building. These studies suggest that the relationship between executive management and middle managers is important in realising an enhanced middle manager role.

However, others are more optimistic that middle managers can take up an enhanced role in strategic change and set out the necessary conditions so that there is a full, enhanced contribution from middle managers. Much of this emphasises changes in organisational stmcture. For example, Frohman and Johnson (1993: 85) talk of, 'knocking down the walls', where 'balanced' firms add a number of stmctural arrangements that enable their middle managers to establish a network inside and outside the organisation, such as human resource systems that support and value lateral contributions of middle managers. Other leading protagonists argue that the

organisation needs to, 'rethink the roles of its key players', importantly middle managers and conceive the role of middle level managers as 'knowledge engineers' (Nonaka and Takeuchi, 1995: 158), who fiinction as facilitators of knowledge creation, involving top management and front-line workers in a management process Nonaka and Takeuchi *{ibid:* 49) call 'middle-up-down' management. Kanter (1982) sets out organisational supports to hamess the creativity of middle managers, such as multiple reporting relationships and frequent and smooth cross-functional contact. Others, such as Evans (1992), focus developing middle management leadership ability to implement the necessary organisational changes.

Other commentators focus upon characteristics of strategic change. For example, Frohman and Johnson (1993) argue that the conception and implementation of strategic change may act against aspirations that middle managers take on an enhanced role. Middle managers may be excluded from conception but expected to engage in implementation, as a result of which they may resist implementation. This leads to a 'gap in the middle' (Frohman and Johnson, *ibid.).* Smith (1997) also draws our attention to the way in which strategic management is conceived and its impact upon the role of the middle manager:

'The most important determinant of the failure of the large corporation is top management strategic decision-making; the extensive, semi-autonomous stmcture of middle management was historically a direct by-product of those decisions' (Smith, 1997: 198).

It appears that middle managers have traditionally been excluded from decision-making in the formulation of strategic change according to such commentators.

Therefore, it may be that their role is unlikely to be enhanced beyond the implementation role.

The ideas above will be elaborated upon in the chapter 2 where the strategic management literature is considered in relation to the role of middle managers and the necessary conditions for a reshaped or enhanced role for middle managers are debated. However much of this commentary in the next chapter about strategic change and an enhanced role for middle managers tends towards the speculative or aspirational This reflects the commentary reported in this chapter about an empowered or entrepreneurial middle manager (Frohman and Johnson, 1993; Kanter, 1982, 1983; Nonaka, 1988; Nonaka and Takeuchi, 1995), which was also speculative. Therefore, the need remains for empirical work to assess the realisation of such aspirations.

1.5 The Research Gap

The two debates, that the future is pessimistic for middle managers and that the future is more optimistic for middle managers, seem contradictory. There appears to be a lack of consensus in debate around the role of middle managers in organisations. This is reflected in the titles of papers, both popuhst and academic. On the pessimistic side of the debate, there are titles such as - 'Cutting Out the Middle Manager' (Arkin, 1990), 'Too Much Round the Middle' (Gates, 1992) and 'The Reluctant Manager' (Scase and Goffee, 1989). These vie with titles which assert a more optimistic future for middle managers such as - 'Putting Management back into the Middle' (Lebor and

Stofinan, 1988), 'Middle Managers as Innovators' (Kanter, 1982) and 'Moving from Crisis to Empowerment' (Frohman and Johnson, 1993).

This lack of consensus, alongside the speculative nature of much of the pessimistic and optimistic commentaries about the changing role of middle managers, suggests that research should attempt to gain a richer in-depth understanding of the changing role of the middle managers. For example, Dopson and Stewart (1990) argue:

'If writing in this area is to amount to anything more than armchair theorising, it is cmcial that more empirical work is done. Failure to do so may lead to yet more sweeping assertions about the fiiture of middle management' (Dopson and Stewart, 1990: 15).

The call for more empirical research by Dopson and Stewart (1990) is supported by Smith (1997), who also argues there is limited scholarly data, which analyses the consequences of restmcturing for middle managers. This neglect is typified by much of the literature which claims to study management behaviour and managers in role, but actually focuses almost entirely on executive management - the layer of management which provides the strategic direction of the organisation, often the Board. For example, Mintzberg's *'The nature of managerial work '* (1973) assumes that executive management activities are identical to those at junior level. Even Watson (1994), though he is well aware of the emotional strains on managers, never fully explores the difference between being at the top and in the middle (Tumbull, 1998).

One particular feature that distinguishes the middle manager experience in organisations from that of executive managers, is that they are encouraged to be

entrepreneurial and innovative while their ranks are reduced (Newell and Dopson, 1995; Daudi et al 1997; Smith, 1997). As Smith (1997) comments upon these tendencies:

'On one hand, a constant stream of reports and studies suggests a significant and unprecedented decline in the employment conditions and status of middle levels of management in large, historically oligopolistic firms. On the other, we live in an era that devotes considerable attention to the critical role middle managers play in improving ... competitiveness. Insofar as these two tendencies appear as separate processes, they seem extremely contradictory. Yet they actually reflect the same process: an agenda for transforming the function of management by targeting corporate middle managers simultaneously as objects and agents of corporate decline and reconstmction' (Smith, 1997: 4-5).

This is an interesting comment since, in portraying theses tendencies as one process, which encompasses both the de-layering of middle managers and the possibility of an enhanced role, Smith (1997) suggests that both writers who are proponents of the pessimistic scenario for middle managers and those who make more optimistic assertions, may have foundation to their arguments. The suggestion is that reduced numbers of middle managers may take up an enhanced or empowered role. Such a process was evident in the case of General Electric, reported earlier, which was cited in Frohman and Johnson (1993).

Therefore, firstly, the thesis examines the possibility of an enhanced role for middle managers and what this might constitute. This will address the empirical gap identified by Dopson and Stewart (1990, 1993) and Smith (1997). Alongside this, the thesis will consider what organisational conditions impact upon the realisation of any enhanced role, including that raised about the characteristics of strategic change but also about the impact of organisation stmcture and human resource policies and

practices. What the strategic management literature discusses in relation to all these issues is considered in the next chapter.

Chapter 2

The Role of Middle Managers in Strategic Change

2.1 Introduction

In the previous chapter the possibility of a re-shaped or an enhanced role for middle managers was raised. A question is raised in this suggestion which asks what this role might be. The literature discussed in chapter 1 suggests that an enhanced role would involve middle managers to a greater extent in strategic change beyond the implementation of deliberate strategy. For example, Dopson and Stewart (1990: 1993) conclude that middle managers become closer to executive management and the strategy and policy arena. Frohman and Johnson (Frohman and Johnson, 1993; Johnson and Frohman, 1989;) talked of the involvement and participation of middle managers in organisational change and Nonaka and Takeuchi (1995) conceive of middle managers as a strategic knot between the vision of executive management and the rest of the organisation (see section 2.3.1(a)(ii)). Therefore, in order to elaborate upon the re-shaped or enhanced role that middle managers may take up, this chapter will review the relevant strategic management literature.

The principle by which this chapter is set out, is to move from a general discussion of the schools of strategic management that are relevant to the public sector setting in which empirical investigation takes place, to literature that specifically discusses the role of middle managers in strategic change.

Firstly, the generic strategic management literature will be reviewed for its implications for the middle manager role in strategic change. However, such a review will be limited to the strategic management literature that is considered relevant to the public sector context in the UK in which the empirical cases are placed. Ashbumer et al (1994) and Pettigrew et al (1992) highlight that both top-down rational planning (Ansoff, 1965; Chandler, 1962, 1977; Sloan, 1963) and the processual view of strategic management are relevant. The latter includes incrementalist strategic management approaches (Lindblom, 1959, 1968, 1979; Quinn, 1978, 1980, 1982) as well as the model of strategic change developed by Pettigrew et al (1992). From this, the characteristics of sfrategic change, which might facilitate or inhibit an enhanced role for middle managers, will be identified. The characteristics discussed are - (1) the balance between deliberate and emergent strategy, (2) the extent to which formulation and implementation of strategic change should be intertwined or separated and the impact of this upon the role of the middle manager. The relationship between cenfral government and NHS tmsts, between executive management and middle management and between the medical group and middle managers are also important influences upon the role of middle managers in strategic change when discussing these characteristics and this too will be discussed, mainly in chapter 3.

Secondly a framework developed by Floyd and Wooldridge (1992, 1994, 1997) to illustrate the involvement of middle managers in strategic change will be outlined so that any role beyond implementation of deliberate strategy can be distinguished and the conditions necessary for other roles elaborated upon. Therefore, towards the end of this second part of the chapter, the discussion tums to other aspects of

organisational context that impact upon an enhanced role for middle managers, such as organisational stmcture and organisation development and management development, which are raised in the work of Floyd and Wooldridge (1992, 1994, 1997).

The discussion of the impact of the contingent factors, such as the way in which strategic change is conceptualised, organisational stmcture and organisation development and management development, upon the role of middle managers will buih upon the ideas already introduced in chapter 1.

2.2 Strategic Management Literature

The analytic distinctions drawn between approaches to strategic change, which are important in the NHS, are evident in the work of Pettigrew et al (1992) and are explicitly set out by Ashbumer et al (1994). Firstly, the strategic change process may be characterised as top-down or bottom-up. This question is closely linked with whether strategic change is separated or not into formulation and implementation stages. Secondly, we can focus upon the distinction between deliberate strategic change and emergent strategic change. Deliberate sfrategic change emphasises that intended strategy is wholly or mostly realised. This is associated with top-down approaches to strategic change. Emergent strategic change emphasises that strategic change may not be intended or planned for. This is emphasised in bottom-up approaches.

When these analytic distinctions are considered in relation to schools of strategic management as defined by Whittington (1993), then two schools of strategic management appear to be most relevant to the public sector - the Classical School and the Processual School[7]. The Classical School broadly sees strategy as a rational process of long-term planning while the Processual School (this includes incrementalist perspectives and the work of Pettigrew et al 1992), in contrast, sees strategy as emerging from a pragmatic process of bodging, teaming and compromise than from a rational series of grand leaps forward (Mintzberg, 1987).

Within the Processual School (Whittington, 1993), Pettigrew et al (1992) argue that traditionally the pattem of decision-making has been seen as highly incremental in nature in the NHS, where policy is made and re-made continuously through a process of partisan mutual adjustment involving a number of stakeholder groups - 'disjointed incrementalism' (Lindblom, 1959, 1968, 1979). Alternatively, it has been portrayed as 'logical incrementalism' (Quirm, 1978, 1980, 1982), which allows for a greater degree of deliberateness from executive management compared to disjointed incrementalism. However, this view of strategic change has changed in the 1980s where the pace of change has been driven from the top to a much greater extent (Pettigrew et al 1992). Thus, in considering strategic change more generally, as well as incrementalist approaches (Lindblom,*ibid*; Quirm, *ibid.),* in recent years the work of a group of academics emanating from the University of Warwick (Pettigrew and Whipp, 1991; Pettigrew et al 1992; Feriie et al, 1996) is relevant. The framework that Pettigrew et al (1992) develop, suggests that there is a greater need for rational planning and top-down led change in conditions of radical change than there was hitherto.

[7] The other two schools Whittington (1993) identifies are the Systemic School and the Evolutionary School, The former suggests strategic change is a product of embedded social values in an organisation. The latter suggests the market selects survivors and

However, the academic work emanating from the University of Warwick (Pettigrew and Whipp, 1991; Pettigrew et al 1992; Feriie et al, 1996) eschews a pure or extreme top-down approach which emphasises rational planning and deliberate strategic change - the 'Classical School' (Whittington, 1993). Instead, for example, Pettigrew and Whipp (1991) describe change as intentional and emergent, with the additive effects of implementation sometimes overwhelming the original intentions. In later work, Ferhe et al (1996) assert that changes in the public sector have not always gone in the intended direction because they are re-interpreted by different stakeholders to serve other purposes.

Others from the Processual School also criticise top-down rational planning in its pure form. Most notably, Mintzberg and Waters (1982) argue that top-down rational planning in its pure form ignores the enactment of strategic change fiirther down the organisation. Also, within the Procesuual School, the incrementalist approach, as represented by Quinn (1980), asserts that:

'When well-managed organisations make significant changes in sfrategy, the approaches they use frequently bear little resemblance to the rational-analytical systems so often touted in the planning literature' (Quinn, 1980: 105).

However, it is useful to set out the characteristics of the top-down rational planning approach because it still constitutes an element of sfrategic change in the public sector. It may, as Pettigrew et al (1992) suggest, be more important where radical change is necessary. Further, the role of middle managers in organisations cannot be considered in isolation to their relationship with other groups in the organisation, particularly executive management, who may formulate and implement strategic

chooses other organisations to fold.

change in a top-down way. Therefore, in the next section of this chapter, we consider the implication of top-down rational planning for the role of the middle manager.

2.2.1 Classical School

In this section, the characteristics of top-down rational planning will be described. Following this, a critique of top-down rational planning will be outlined, drawing upon the work of Mintzberg (Mintzberg, 1987, 1991, Mintzberg and Waters, 1982, 1985). Some of the issues raised in the critique of top-down rational planning will then be discussed more specifically in relation to the NHS. Throughout this section imphcations for the role of the middle manager will be emphasised.

2.2.1 (a) ***Top-Down Rational Planning***

The roots of the top-down rational planning approach to strategic change lie with the work of Igor Ansoff, whose book, *Corporate Strategy* (Ansoff, 1965), was subtitled *'an analytic approach to business policy for growth and expansion'*. Together with Chandler (1962, 1977) and Sloan (1963), he established a perspective which Whittington (1993) calls the 'Classical' school of strategic thinking. They focus upon strategic change as deliberate and rational, directed towards profit-maximisation, and very much the restricted domain of executive management. To do this they draw heavily on notions of military leadership and view corporations as hierarchies to be directed from the top (Segal-Horn, 1998).

Mintzberg and Waters (1985) argue that at least three conditions need to be satisfied for such a deliberate strategy, in its perfect form, to be realised. Firstly, there must have existed precise intentions in the organisation, articulated in a relatively concrete level of detail, so that there can be no doubt about what was desired before any actions were taken. Secondly, because organisation means collective action, to dispel any possible doubt about whether or not the intentions were organisational, they must have been common to virtually all the actors. Thirdly these collective intentions must have been realised exactly as intended, which means that no external force (market, technological, political, etc.) could have interfered with them. The environment in other words must have either been perfectly predictable, totally benign, or else under the full control of the organisation

Thus, taking account of this, any empirical study of strategic change should consider the extent to which collective intentions exist and whether these intentions are articulated in detail. Perhaps more importantly, in the context of the NHS, one of the issues to be assessed is the extent to which the extemal environment is unpredictable, which would then mihtate against deliberate strategy. More importantly, in the light of the research question in this thesis, Mintzberg and Waters (1982) claim that top-down rational plarming, which emphasises deliberate strategy, regards formulation and implementation of strategic change as separate and the formulation of sfrategic change as the exclusive domain of executive managers. This assumption appears to limit the role of middle managers to that of being mere implementers of a deliberate strategy formulated separately higher up the organisation.

However, Mintzberg (1987, 1991) does not dismiss the classical school entirely. Instead he asserts that strategy walks on two feet - one deliberate and one emergent:

' We shall get nowhere without emergent teaming alongside deliberate planning. If we have discovered anything at all these many years, it is, first that the conception of a novel strategy is a creative process (of synthesis), for which there are no formal techniques (analysis), and second, that to program these strategies throughout complex organisations and out to assenting environments, we often require a good deal of formal analysis' (Mintzberg, 1991: 465).

The suggestion here is that approaches, which emphasise deliberateness, such as top-down rational planning, should not be completely dismissed in his view and importantly this is because purely emergent strategy precludes control by executive management (Mintzberg, 1987).

2.2.1 (b) *Top-Down Rational Planning in the NHS*

While policy and strategic change in the NHS will be discussed in detail in the next chapter, it is useful at this point to highlight some of the issues raised in the literature about top-down rational planning, which are particularly relevant to the NHS.

Within the NHS, Wall (1999) picks up on the issue of control raised above by Mintzberg (1987) and asserts that the degree of freedom allowed to middle managers is difficult to judge but that some boundary needs to be drawn between flexibility and adherence to agreed frameworks. Therefore, both generally in Mintzberg's work (Mintzberg, 1987, 1991) and specifically in the NHS in Wall's work the question is raised about the extent to which the deliberate top-down rational planning element

should be emphasised. Further, if deliberate top-down planning is in evidence, its impact upon the role of the middle manager should be considered.

Feriie et al (1996) consider this question within the empirical context of the NHS. They suggest that in earlier periods than that being considered in this thesis - i.e. post-1990 period - that there has been a local implementation gap as government preferences on priorities were not always accorded precedence locally. They argue that:

'A sfrong element of unplanned change has been apparent, with the emergence of unanticipated consequences and unexpected organisational forms. The change process cannot be characterised by a simple and intentional 'planned change' model but seems to develop a complex logic and a momentum of its own' (Feriie et al 1996: 231).

Harrison et al (1992) describe the implementation gap as a 'chasm' (:90) and trace it back to the 1974 NHS re-organisation. They cite Gunn (1978):

'When implementation involves, as it often does, irmovation and the management of change, then there is particularly high probability of suspicion, recalcifrance or outright resistance from affected individuals' (Gunn, 1978: 175).

While Harrison et al (1992) highlight the medical group as the most important contributor to implementation failure, this thesis draws attention to the influence of middle managers in the implementation of deliberate strategy. This is one of the downward influencing roles of middle managers identified by Floyd and Wooldridge (1992, 1994, 1997) discussed in the second part of this chapter (see section 2.4). In the view of the Classical School, middle managers may 'distort' planned strategy.

More recently, central intervention appears to be more influential so that the implementation gap is closed. A top-down, change strategy driven from the centre has succeeded in delivering change even when unintended as well as intended consequences have been evident (Feriie et al 1996). In relation to this, Feriie et al *{ibid.)* raise the question whether a distinctive and more sophisticated central implementation strategy has characterised a post-1990 period of acceleration in the rate and scope of change at a local level of the public sector. They assert that much more attention has been given to devising an implementation strategy as well as to the initial formulation of policy. In earlier work Pettigrew et al (1992) found that:

'A broad vision seemed more likely to generate movement than a blueprint. Such broad visions were found to have significant process and implementation benefits in terms of commitment-building and allowing interest groups to buy into the change process, and allowing top-down pressure to be married with bottom-up concem' (Pettigrew et al, 1992: 277).

In terms of the fiinction of the NHS Board, Feriie et al *{ibid.)* stress that these boards, 'typically approached strategy development in a processual and iterative way, rather than through formalistic exercises in rational plarming' (Feriie et al, 1996: 233).

Therefore, from Feriie et al's work (1996), there is a suggestion that the 'centre' (policy-makers at national level and executive management at tmst level) attempt to influence strategic change in a way that is similar to that described as an 'umbrella' strategy by Mintzberg and Waters (1985). This would appear to allow scope for middle managers to make an enhanced contribution to strategic change:

'An umbrella strategy is one, which is appropriate where leaders have only partial control over other actors in an organisation. They set general guidelines for behaviour - define the boundaries - and then let other actors manoeuvre within them. When an

environment is complex and perhaps somewhat uncontrollable and unpredictable as well, a variety of actors in an organisation must be able to respond to it. In other words, the pattems in organisation actions cannot be set deliberately in one central place, although the boundaries may be established there to constrain them. From the perspective of the leadership (if not the individual actors), therefore, strategies are allowed to emerge within these boundaries not only deliberate and emergent (intended at the centre in its broad outlines but not in its specific details), but also 'deliberately emergent' (in the sense that the central leadership intentionally creates the conditions under which strategies can emerge)' (Mintzberg and Waters, 1985: 263).

That the umbrella sfrategy is relevant is emphasised by Mintzberg and Waters (1985) who claim, 'virtually all real world strategies have umbrella characteristics'. Mintzberg and Waters *{ibid.)* also support more research in the area stating, 'it would be interesting to know how different types of strategies perform in various contexts and also how these strategies relate to those defined in terms of specific content' (Mintzberg and Waters, 1985: 269).

In conclusion, there are a number of issues raised, by Pettigrew et al, 1992, Feriie et al, 1992 and Mintzberg and Waters (1985), about top-down rational planning that are relevant to the question of the influence of middle managers in strategic change in the NHS. Firstly we need to consider the balance between emergent and deliberate change, and its implications for middle manager influence. The question is raised of how much control should be surrendered by executive management to those who are closer to the operational situation who have the information current and detailed enough to shape realistic strategies. Secondly, linked to this, is the influence of centre-periphery relations. On one hand, the role of the middle manager is likely to be influenced by the relationship between the centre at a national level and individual tmsts in the implementation of strategic change. On the other hand, at a local level, the role of the middle managers is likely to be influenced by relationship they have with the Board and other executive managers at the corporate centre.

2.2.2 The Processual School

2.2.2 (a) *Incrementalist Approaches*

Given that disjointed incrementahsm (Lindblom, 1959, 1968, 1979) has been superceded by logical incrementahsm as a model for policy in the public administration literature, discussion will focus upon logical incrementalism (Quinn, 1978, 1980, 1982). However, as logical incrementalism builds upon disjointed incrementalism, it is usefiil to outline the characteristics of disjointed incrementalism.

2.2.2 (a) (i) *Disjointed Incrementalism*

The characteristics of disjointed incrementalism are described in *'The Science of Muddling Through'* (Lindblom, 1959). In this, Lindblom argues that policy is made and remade continuously as successive negotiations take place through a process of partisan mutual adjustment between a plurality of interest groups who operate in the decision-making arena. Radical change is inappropriate since only past sequences of policy-making and change can give policy-makers knowledge about the consequences of a policy choice. It therefore follows that incremental change is appropriate because it utilises knowledge of past consequences of policy choice as a guide. In this way a simplification of analysis is achieved by concentrating on policies that differ only incrementally. This offers a systematic altemative to theory since it's based upon what worked before, and will, as Lindblom claims, be superior to a futile attempt at superhuman comprehensiveness.

The main value of Lindblom's work, in relation to the research question in this thesis, is that it initiated the view of strategic change in the public sector as an emergent process:

'The School of Muddling Through initiated this school [the Teaming School]. Lindblom suggested that policy-making [in government] is not a neat, orderly, confrolled process, but a messy one in which policy-makers try to cope with a world that they know is too complicated for them. Lindblom's notions may have violated virtually every premise of 'rational' management. But they stmck a chord by describing behaviour with which everyone was familiar, and in business no less than government' (Mintzberg et al 1998: 176).

In a later book (Lindblom, 1968) summarised his theory with the statement that:

'Policy-making is typically a never-ending process of successive steps in which continual nibbling is a substitute for a good bite ... the piecemealing remedial incrementalist or satisficer ... is a shrewd, resourceful problem-solver who is wrestling bravely with a universe that he is wise enough to know is too big for him' (Lindblom, 1968: 25-27, cited in Mintzberg eLal, 1998).

Also of relevance to the research question is that Lindblom emphasised the political element of strategic change and a process of mutual adjustment between various actors in the change process. This would appear to allow for greater influence, upon that process, by middle managers than that evident in top-down rational planning.

2.2.2 (a) (ii) *Logical Incrementalism*

However, disjointed incrementalism 'stops short of a theory of sfrategy formation' (Mintzberg et al 1998: 180) and has been superseded by logical incrementahsm. Quinn (1978) draws a distinction between the variant of incrementalism that he

elaborates upon - logical incrementalism - and disjointed incrementalism that is described by Lindblom (1959):

'Many power-behavioural studies [including Lindblom] have been conducted in settings far removed from the realities of strategy formation. Others have concentrated solely on human dynamics, power relationships, and organisational processes and ignored the ways in which systematic data analysis shapes and often dominates cmcial aspects of strategic decisions. Finally, few have offered much normative guidance for the strategist' (Quinn, 1978: 8).

Quinn (1978, 1980, 1982) picked up where Lindblom left off (1959, 1968, 1979). He agreed with Lindblom on the incremental nature of the strategic change process but not on its disjointedness. Instead he felt that central actors pulled sfrategic change together and directed it towards a final strategy (Mintzberg et al 1998). In his description of logical incrementahsm (Quinn, 1978, 1980, 1982) the reahsation of strategic change is a result of rational planning elements of strategic change being combined with power-behavioural elements. Quinn (1978, 1980, 1982) summarises his findings as follows:

'-Neither the 'power-behavioural nor the 'formal systems planning' paradigm adequately characterises the way successfiil strategic processes operate.

-Effective strategies tend to emerge from a series of 'strategic subsystems', each of which attacks a specific class of strategic issue (e.g. acquisitions, divestitures, or major reorganisations) in a disciplined way, but which is blended incrementally and opportunistically into a cohesive pattem that becomes the company strategy.

-The logic behind each 'subsystem' is so powerful that, to some extent, it may serve as a normative approach for formulating these key elements of sfrategy in large companies.

-Because of cognitive and process limits, almost all of these subsystems - and the formal planning activity itself- must be managed and linked together by an approach best described as 'logical incrementalism'.

-Such incrementalism is not 'muddling'. It is a purposeful, effective, proactive management technique for improving and integrating both the analytical and behavioural aspects of strategy formation' (Quirm, 1978: 8).

Strategic change is emergent, where, 'successfiil executives link together and bring order to a series of strategic processes and decisions spanning years' (Quinn, 1982: 113). Strategic subsystems, which may not be synchronised with each other, evolve towards this. Quirm claims that, in this process, formulation and implementation of strategic change are intertwined:

'Constantly integrating the simultaneous incremental processes of strategy formulation and implementation is the cenfral act of effective strategic management' (Quinn, 1980: 145).

A number of questions for the role of middle managers are raised if logical incrementalism is descriptively accurate of strategic change in the NHS. Firstly, how does the combination of rational planning and power-behavioural elements of strategic change inherent in logical incrementalism impact upon the role of middle managers. Secondly, a focus upon strategic subsystems may be fruitful in bringing out the influence of middle managers. Thirdly, how should these subsystems be brought together and hence what control should executive management exert over middle managers.

In addition, in the light of centre-periphery relationships discussed in the next chapter, precipitating events such as government interventions are highlighted in Quinn's work (Quinn, 1978, 1980, 1982). For example, Quinn's study shows that almost all companies cite government as an important force causing significant change in their

strategic postures. Yet few have cohesive strategies to deal with this since in this realm uncontrollable forces dominate. Quinn argues, for this reason:

'Logical incrementalism is likely to remain the essential thread linking together the formal information gathering, analysis, testing, awareness building, consensus broadening, coalition creating, and other behavioural and power dynamic actions needed to achieve an effective strategy in this realm' (Quinn, 1980: 37).

Furthermore, Quirm describes executive management plans as 'frameworks' only, since further information may be available in the future which would impact upon strategic change. Whilst the source of fiirther information is not articulated, implicitly there is scope for the input of middle managers here because, 'executives may be able to predict the broad direction, but not the precise nature, of the ultimate sfrategy which will result' (Quinn, 1982: 111). Such a description appears consistent with Mintzberg and Water's (1985) description of an umbrella strategy that may allow for an enhanced contribution towards strategic change from middle managers. There may also be scope for middle manager influence because they may provide the linking pin which solves the problem of, 'how top managers first sense the need for strategic change?' (Quinn, 1980: 103).

However, there are some points raised in Quinn's work (Quinn, 1978, 1980, 1982), which highlight some of the limits to any enhanced middle manager role within the model of strategic change proposed. Firstly, executive management prescribes the broad framework within which the middle manager role of gathering, analysing and presenting information takes place. Secondly strategic options, at least at a subsystem level, flow upwards from lower levels, 'but it remains the prerogative of top management to support or kill such lower level initiative' (Quinn, 1980: 129). Further

Quinn suggests that middle managers may be by-passed in this process (Quinn, 1980: 106). Thirdly, Mintzberg et al (1998), in interpreting Quinn's work, assert that the separation between formulation and implementation is maintained in logical incrementalism and with it strategists and everyone else are separated, with the former consisting of the team of top executives[8]. Thus, any enhanced role for the middle manager would appear tempered by the fact that executive management formulate sfrategy and middle managers merely implement it.

There appear to be competing tensions that impact upon the potential for any enhanced role for middle managers within the logical incrementalism framework for strategic change. On one hand, middle managers may have an important role as linking pins and may be able to bring, to the attention of executive management, information about the need for strategic change. On the other hand, there appears to be a tendency for executive management to control any middle manager influence upon strategic change and therefore inhibit their role in strategic change. Should logical incrementalism be an accurate description of strategic change in organisations, there remains the question of whether it allows for an enhanced role for middle managers, which involves a role beyond the implementation of deliberate sfrategy. Firstly, in the next section 2.2.2(a)(iii), the descriptive accuracy of logical incrementalism will be considered in the NHS. Following this, there will be a fiirther discussion of the likely role for middle managers in the NHS should logical incrementalism be descriptively accurate.

Consideration of logical incrementalism within the NHS contributes towards a need for studies that consider the descriptive accuracy and prescriptive validity of logical

[8] In contrast, Dean et al (1998) suggest that logical incrementalism addresses formulation and implementation simultaneously.

incrementahsm in different contexts. In particular, Quinn (1982) emphasises that the balance of formal and informal processes in strategic change is dependent upon context. A relative emphasis upon informal processes by which strategic change is realised as opposed to an emphaasis upon formal processes, such as top-down planning, may allow for greater middle manager influence in the strategic change process.

The importance of contextual differences is most apparent in the in-depth case studies described in his text (Quirm, 1982). In each of these cases, different characteristics of logical incrementalism are in evidence. In addition, while all the case studies are drawn from the private sector, Quirm recognises that the public sector represents a particularly distinctive context for strategic change. However, he does not elaborate upon the comparative balance of formal and informal processes in each sector, nor about its consequences for the influence of other actors, such as middle managers, in the organisation.

2.2.2 (a) (iii) *Incrementalism in the NHS*

Again, while policy and strategic change in the NHS will be discussed in more detail in the next chapter, at this point, it is useful to discuss some of the issues raised more specifically in the context of the NHS. The incrementahst perspective has historically been well represented, perhaps even dominant, in studies of decision-making in health care settings. The received wisdom is that change will take place through successive, limited and negotiated shifts - that is, there is a presumption of incrementalism in decision-making in health care organisations (Pettigrew et al 1992).

Pettigrew et al (1992) have a mixed view of the validity of logical incrementalism under New Public Management[9]. On one hand, Pettigrew et al *{ibid.)* build a model that has similarities to incrementalist models. Both Pettigrew et al *{ibid.)* and Quinn (1978, 1980, 1982) criticise extreme forms of top-down rational planning and are informed by a definition of strategy as a 'pattem in a stream of actions' (Mintzberg and Waters, 1985). More specifically both Pettigrew et al (1992) and proponents of incrementalism (Lindblom, 1959, 1968, 1979; Quinn, 1978, 1980, 1982.) recognise the inhibiting factors for strategic change in the public sector that necessitate a high degree of politicking. Additionally both Pettigrew et al (1992) and the variant of incrementalism described by Quinn (1978, 1980, 1982) - logical incrementalism - recognise the need for some element of rational planning to direct emergent change through consistently visible pressure from the higher tier. Thus, Pettigrew et al (1992: 14-15) rehearse arguments for advantages claimed for incrementalism that it is realistic and descriptively vahd (Mintzberg, 1990). Further, Ferhe et al (1996: 150) assert that Quinn's view of logical incrementalism is productive since it incorporates iteration from formulation of strategy to implementation and back again, thus allowing for responses to environmental pressures to feed back into the formulation process and produce a more coherent strategy. However Pettigrew et al (1992) retain reservations about the incrementalist literature:

'...recent work has questioned whether the descriptive validity of incrementalism is as strong in the new conditions of the 1980s ... we may need to go beyond incrementalist perspectives in order to understand the behaviour apparent in health care organisations of the 1980s' (Pettigrew et al 1992 :15).

[9] Pettigrew et al (1992) do not clearly distinguish between a critique of incrementalism in general and logical incrementalism in particular.

Again later they assert:

'While incrementalism has perhaps been the dominant approach to the study of decision-making in healthcare systems, it is doubtful whether it is an adequate explanation of the discontinuities evident' (Pettigrew et al, 1992: 28).

Therefore, there appears some question of whether logical incrementalism is descriptively accurate or prescriptively valid in the NHS currently (Feriie et al, 1996). Further, there is no consideration of the likely influence of middle management upon strategic change in the NHS should logical incrementalism hold, although generally, as suggested in section 2.2.2(a)(ii), the influence of middle managers in logical incrementalism appears subject to competing tensions. The question remains whether middle managers have an enhanced role or a diminished role under logical incrementalism.

There has been one study of logical incrementalism that comments upon the role of middle managers in this, which may be relevant to considering the influence of middle managers upon strategic change in the NHS. In this, Johnson (1988) alludes to an influential role for middle managers by highlighting the influence of boundary-spanning managers, who, 'sensed the need to change and in some cases tried to put into effect such changes' (Johnson, 1988: 233). This is a role that will be fiirther elaborated in the second part of this chapter, where a typology of middle manager involvement in strategic change will be outlined (see section 2.3), and will be considered in the subsequent emprical chapters (chapters 5 to 8). However, before this, the work of Pettigrew et al (1992) will be discussed.

2.2.2 (b) *The Work of Pettigrew etal (1992)*

The work of Pettigrew et al (1992) had developed from eariier work by Pettigrew (1985) and Pettigrew and Whipp (1991) and has been developed fiirther by Feriie et al (1996), all of which emphasises the emergent part of strategic change as much as the deliberate element. As outlined in the relevant sections above they raise questions about the validity of those approaches, such as top-down rational planning, which emphasise strategy as mostly or wholly deliberate. They also suggest that incrementalist approaches are not descriptively accurate under the conditions of 'New Pubhc Management' (Feriie et al, *ibid.).*

As an altemative model, Pettigrew et al (1992) and other associated work by Feriie et al (1996), Pettigrew (1985), and Pettigrew and Whipp (1991), propose a model of strategic change which takes account of the problems they raise in relation to deliberate approaches to strategic change and which builds upon incrementalist approaches. They place emphasis upon the process by which strategic change emerges from a combination of influences within the organisation. This approach is based upon a definition of strategy as 'a pattem in a stream of actions' (Mintzberg and Waters, 1985) where formulation and implementation of strategic change is intertwined.

The model developed outlines key features of intemal and extemal context and action to account for success or failure in change efforts and for differences in the rate and pace of change. In their study, Pettigrew et al (1992) align themselves with a perspective of strategic change which emphasises that it is, 'intentional and emergent

with the additive effects of implementation sometimes overwhelming the original intentions' (Pettigrew et al, 1992 :297). They seek to remedy the weaknesses of much health care research, suggesting it is, 'insufficiently processual, comparative, pluralist, contextual and historical' (Pettigrew et al, 1992: 27), by adopting a comparative, longitudinal and issue-based case study approach to methodology.

Cmcially Pettigrew et al (1992) argue that there is a need for inclusivity in the management of strategic change and assert that, 'in order to change the world one must live with it ... the politics of generating support and legitimacy for a new order normally require keeping one foot in the present while the other stretches forward' (Pettigrew et al, 1992: 299). The implication of the view of sfrategy held by Pettigrew et al *{ibid.)* is that those strategies which are imposed top-down, without incorporating other organisational constituencies, are unlikely in practice to be effective, realised sfrategies (Segal-Hom, 1998). Thus, strategic change as process not only reflects the views of executive management, but represents a set of pragmatic compromises between various stakeholders in the organisation (Pettigrew, 1985). The question this thesis is concemed with, is to what extent middle managers are influential organisational stakeholders in the realisation of strategic change.

Further, Pettigrew et al (1992), like Quinn (1982), emphasise that the context for strategic change is important. Their concem with context reflects earlier work by Whipp and Clark (1986) and their own earlier work (Pettigrew and Whipp, 1991), where the way in which antecedent factors play a part in shaping the current situation for an organisation, was emphasised. Pettigrew et al (1992) build upon this in constmcting their model of change. Firstly, they distinguish between inner and outer

context for change. Outer context refers to the national economic, political and social context for a hospital tmst as well as the perception, action and interpretation of policies and events at national, regional and host health authority level[10]. Social movements and long-term professionalisation processes also form important aspects of the outer context. Inner context refers to the ongoing strategy, culture, management and political processes of the tmst which help shape the processes through which ideas for change proceed. Pettigrew et al *{ibid.)* suggest that there is an overemphasis upon the latter irmer context in the generic organisational change literature relative to outer context. They also suggest that, generally, there has been a neglect of context, and the role of powerfùl groups within it, altogether. Further, they distinguish between 'receptive' and 'unreceptive' contexts for change. This neglect of context has produced a situation in which myths abound about rational problem-solving processes and linear implementation. Thus, as was discussed in the previous chapter, this manifests itself in the over-mechanistic transfer of managerial practices from the private to public sectors.

In an attempt to address this problem, and to combine political and cultural[11] elements of analysis, Pettigrew et al (1992) draw attention to context. They see this as something that is, 'not inert or objective entities' (Pettigrew et al 1992: 9), but as something whose meaning can be managed to create a receptive context for change (They also recognise that some contexts can be unreceptive to change).

[10] Pettigrew etal (1992 use different labels such as District Health Authority. This reflected the structure of the NHS at the time.

" It is not the intention of this thesis to dwell upon organisational culture as a concept. There has been a considerable amount of work focused on the concept of organisational culture generally (see Martin and Frost (1996) for summary of 'culture wars' debate and specifically in the NHS (Harrison et al (1992) represents a text focused upon this concept). Further, Feriie et al (1996) also move away fi-om using this concept, suggesting it is but one strand of New Public Management policy. The thesis is concemed with the top-down nature of any change attempt, culture management or not, and its assumption that strategic change is deliberate.

One of the most critical connections identified in their findings is the way actors in the change process mobilise the contexts around them and in doing so provide legitimacy for change. Pettigrew et al (1992) argue that key stakeholders can advance different accounts of reorganisation by creating or questioning legitimacy. Thus, on one hand, the extent to which executive management can define meanings for middle management is raised as an issue. On the other hand, there may be circumstances under which middle management opposition is successful In addition, middle managers themselves may be able to legitimise their ideas and actions and therefore define meanings for executive management.

However, Pettigrew et al (1992) does not dismiss a top-down rational planning element. They argue that the political and cultural elements of strategic change should be complemented by 'analytical and conceptual skills in policy analysis' (Pettigrew et al, 1992: 297). Further, they assert that this combination of grand plans and local circumstances necessitate, a need to combine top-down pressure and bottom-up concem. Overall, there appears to be a possibility for an enhanced role for middle managers in Pettigrew et al's *{ibid.)* conception of strategic change, since there is scope for emergence, bottom-up concem and a political element in it.

However, Pettigrew et al (1992) do not emphasise the influence of middle managers upon the realisation of strategic change in the NHS. Instead they emphasise the influence of other groups such as the Board or the medical group. The relative silence around the role of middle managers is rectified in later work (Feriie et al 1996). Feriie et al *{ibid.)* suggest that middle managers can be developed with a powerful combination of professional expertise and managerial competence. Interestingly they

suggest that instead of becoming 'surrogate' general managers, professionals apply their past professional and caring values in their new middle manager role. They assert that this hybrid professional manager forms an important bridge between managers and professionals but question the stability and sustainability of this role. While this seems to rectify an earher lack of emphasis upon middle managers in strategic change, it is necessary to carry out research to identify the conditions, which may facilitate an enhanced role for middle managers. To further this debate, this chapter now focuses upon that literature, which specifically examines the role of middle managers in sfrategic change.

2.2.3 Strategic Management in the Public Sector

On the one hand, studies have argued that the importance of strategy is overstated in the public sector. It is suggested that this is due to a wider range of stakeholders in the public sector that results in a more political process than that in the private sector so that rational planning is likely to be less effective. On the other, it has been argued that strategy is important as a process to bring the various stakeholders together and that moreover, its importance has increased in the face of policy interventions in the public sector. As the introduction to this section, each of these viewpoints will be taken in tum. Firstly, the argument that strategic management is increasingly important in the public sector will be summarised. Secondly, the problems of strategic management and the limits of rational planning in the public sector will be discussed. This will draw upon the work of Mintzberg (1979), which conceived organisations such the NHS as a 'professional bureaucracy'. In the light of this in the NHS, as discussed in sections 2.2.1 (b) and 2.2.2, there appears a need for a greater emphasis

in the strategic management process upon the political element of change and implementation, as well as formulation.

2.2.3 (a) *Strategic Management* *is Necessary*

Kester (1999: 67) summarises the case for strategic management in the public services. Firstly, if the concept is interpreted as a process, which helps managers to think through aspects relating to their organisation's purpose and objectives, directions and implementation, then it appears to be generic to all sectors. Second, concem with management and strategy in the public sector is not merely a recent phenomenon. Most importantly, incorporating strategic management in the public services recognises that these organisations have been transformed in recent years. The collective impact of policy changes has opened up 'a number of fundamental choices regarding role and processes, thus strengthening the case for a more corporate strategy' (Leach, 1996: 7). As a result central government still continues to demand strategic plans from an increasing number of public sector organisations against which performance is judged (Kester, 1999). Such requests are illustrated in chapter 5 about the business plarming case (see sections 5.2.3 and 5.3.3). A number of academic studies have presented evidence of the importance of sfrategic management in the public sector.

In the health sector, for example, Shortell et al's (1990) study of US health care organisations demonstrated strategic choices made by executive management as one of the key factors in competitive success. In reviewing their study, Ashbumer and Fitzgerald (1994) highlight that strategy was a result of a, 'collaborative processes

which involve the professionals and the clinicians in particular, if they are to be successfully implemented' (:7). Ashbumer and Fitzgerald (1994), citing the study by Pettigrew et al (1992) as evidence also suggest strategy to be important in the UK. Pettigrew et al *{ibid.)* show that the most effective district health authorities at implementing change in their research, which compared a number of case studies, maintained a consistent strategic direction over time, despite the competing demands of their environment.

However, approaches to strategy might need to be significantly different in private and public sectors (Elcock, 1993). It is to this that we tum, firstly examining the particular characteristics of the NHS.

2.2.3 (b) *Strategy as Problematic*

While the constraints upon strategic management in the public sector have been revealed in sections 2.2.1 and 2.2.2 in the discussion of the limits of rational top-down planning and incrementalism, it is worth elaborating upon issues connected to strategy in the public sector context. Elcock (1993) explains why sfrategy in a not for profit organisation may be less straightforward than in a for profit organisation:

'In not for profit organisations, especially those in the public domain, there is no uncontested goal which provides a criterion for choosing options ... There are many stakeholders in public organisations and their goals are multiple and complex and frequently disputed. The absence of a bottom line (like profit) means that sfrategic management in public organisations lacks clarity and certainty in making decisions and the process inevitably involves making political judgements in seeking to satisfy or integrate the multiple and disparate interests involved' (Elcock, 1993: 56-57).

As a result of multiple interests and no clear bottom line, much of the discussion of strategy in the public sector has commented upon the constraints to rational planning in the public sector and contrasted 'strategy as planning' with 'strategy as process', advocating that more attention be paid to the latter. In particular, given the potential range of stakeholders in public sector organisations and the absence of a clear bottom line, the political element of strategic management is as important as any plarming element. In the NHS medical group power in particular is emphasised. In commenting upon the ability of management to execute and control strategy, Mintzberg (1979) emphasised that healthcare organisations exhibit characteristics of a professional bureaucracy in which the professional operating core, the medical group in the case of the NHS, have discretion over their work rather than management. This is further revealed in the next section where the characteristics of a professional bureaucracy are discussed and in chapter 3 (section 3.4.5) when discussing medical group power more generally and its interface with management.

2.2.3 (c) *The NHS as a Professional Bureaucracy*

Mintzberg (1979, 1995) viewed hospitals as exhibiting characteristics of a 'professional bureaucracy'. He defined professional bureaucracies as follows:

> 'Such organisations are bureaucratic without being centralised. Their operating work is stable, leading to predetermined or predictable, in effect, standardised behaviour, but it is also complex, and so must be controlled directly by the operators who do it. Hence the organisation tums to the one co-ordinating mechanism that allows for standardisation and decentralisation at the same time, namely the standardisation of skills (Mintzberg, 1979: 348).

Mintzberg (1979, 1995) emphasised that it is the operating core, consisting of the professionals themselves, that is fully elaborated in a professional bureaucracy rather than the management cadre. Commenting upon the middle line of management he states that:

' ... the middle line in the professional bureaucracy is thin. With little need for direct supervision of the operators, or mutual adjustment between them, the operating units can be very large, with few managers at the level of first-line supervisor, or, for that matter above them' (Mintzberg, 1979: 355).

The professional bureaucracy emphasises authority of a professional nature - the power of expertise. The professional's power derives from the fact that not only is his [or her] work too complex to be supervised by managers or standardised by analysts, but also that his [or her] services are typically in great demand. The standards to which they work originate largely in self-governing associations its operators join with their colleagues from other professional bureaucracies rather than from within the organisation itself Control over his or her own work means that the professional works relatively independently of his colleagues, but closely with the clients he or she serves. Professional bureaucracies cannot rely extensively on the formalisation of professional work, or on systems to plan and control it. The professionals' close relationship with their clients means freedom from having to respond to managerial orders.

Not only do professionals control their own work, but they also seek collective control of the administrative decisions that affect them. On the one hand they seek to control the middle line of the organisation by ensuring it is staffed with 'their own' (for example, the position of clinical director in a hospital). On the other hand, a number

of positions are designated to integrate administrative efforts, for example the position of ward manager, but these managers, 'are in charge of secondary activities; they administer *means* to the major activity carried out by experts' (Etzioni, 1959, cited in Mintzberg, 1979). As a resuh of this, Mintzberg *{ibid.)* suggests that there are two domains in which decisions are made - the professional domain and the administrative domain - and that decisions made in the professional domain, in which middle managers may have little influence, are dominant in terms of its strategic impact.

Mintzberg (1979, 1995) goes on to pose a question that asks to what extent is managers' influence over professionals likely to be limited as a result of professional dominance. His answer to this is one that, 'while the professional administrator may not be able to control the professionals directly, he [or she] does perform a series of roles that gives him [or her] considerable indirect power in the stmcture' (Mintzberg, 1979: 361). He also notes this as necessary because autonomy granted to professionals in a professional bureaucracy means that there is virtually no confrol of the work outside the profession and no way to correct deficiencies that the professionals themselves choose to overlook, these being problems of co-ordination, discretion and of innovation. However, in exerting influence over decisions made in the professional domain, he also notes that trying to confrol the work through direct supervision, standardisation of work processes, or standardisation of outputs is problematic because 'complex work cannot be effectively performed unless it comes under the control of the operator who does it' (Mintzberg, 1979:377).

In later work, Mintzberg (1995) emphasises that sfrategy is pattem in action and related to this, further distinguishes between decisions made by professional judgement, decisions made by administrators and decisions made by collective choice. He suggests that professionals determine the basic mission of the organisation and decide upon the specific services to be offered and to whom. Administration, of which middle managers are part, are limited to certain types of decisions less related to professional work, such decisions about buying and selling property. He also suggests, however, that many decisions are made by collective choice, determined neither by administrators nor by individual professionals. Instead they are handled in interactive processes, which combine professionals with administrators from a variety of levels and units - for example, programmes and departments of various kinds, selection of professionals in some cases and budgets.

From Mintzberg's (1979, 1995) analysis, while control over decisions made in the professional domain in a professional bureaucracy are likely to prove problematic for managers, he does suggest two sources of influence for middle managers over professionals. Firstly, in describing how a manager's power might be executed in strategy under such conditions, Mintzberg (1995) argues that the professional administrator helps members of the professional operating core negotiate their projects through the organisation - for example, in jurisdictional disputes. Secondly managers span boundaries between professionals inside and influences outside the organisation - for example, with government. He suggests that managers might gain power at the locus of uncertainty in various tugs of war between one professional and another and between outside agencies, such as government, and the professional. Thus, he highlights that, while managers in professional bureaucracies lack a good

deal of power compared to counterparts in other types of organisations, 'he or she does perform a series of roles that provide considerable indirect power' (Mintzberg, 1995: 665). Significantly in the hght of possibilities that the middle manager's role might be enhanced in the NHS, he argues that a 'strong professional administrator in seeking to change his [or her] organisation in his [or her] own way, might alter its strategies to make it more effective' (Mintzberg, 1979: 365). However again Mintzberg notes that the administrator 'cannot impose his will on the professionals of the operating core' (Mintzberg, 1979: 365) and must move in an incremental way to realise change. This is also highlighted in later work (Mintzberg, 1995) where Mintzberg argues that managers maintain power as long as the professionals perceive him or her to be serving their interests effectively.

When highlighting the implications of such division of labour for strategy, Mintzberg (1995) argues that there is a, 'paradox [where] strategy is extremely stable at the broadest level and in a state of perpetual change at the narrowest one' (Mintzberg, 1995: 671). A major re-orientation in strategy is discouraged by fragmentation of activity and the influence of individual professionals and their outside associations, But at a narrower level, change is ubiquitous as services are continually being altered, procedures re-designed and clientele shifted.

In summary, on the basis of Mintzberg's (1979, 1995) analysis there appear to be considerable limits to any enhancement of role for the middle manager, particularly as it relates to any control of the professional operating core in a professional bureaucracy. In the case of the NHS the dominant professional group is the medical

group. They are likely to exert considerable constraints upon middle managers' influence on strategic change outside the administrative domain.

It is worth noting that in later work, Mintzberg (1995) emphasises that forces for efficiency and innovation were becoming more evident in professional bureaucracies alongside the force for proficiency. This, promoted through the government policy discussed in the next chapter, may give some space for middle managers to exert influence, albeit indirectly, upon the medical group. However, Mintzberg *{ibid.)* suggests that there is a natural aversion to forces for innovation or efficiency because of the complex nature of the work of professionals in health care. Transferring responsibility, Mintzberg *{ibid.)* concludes, from professional structures to administration will in any case destroy the effectiveness of professionals' work.

Discussion of the interface between the medical group and managers and the implications for strategic change is fiirther elaborated in the next chapter, section 3.4.5. Discussion now moves on to the limits of rational planning under such conditions in which there is a necessity for considerable political acumen from executive and middle managers in realising strategic change.

2.2.3 (d) *The Limits of Rational Planning*

In the discussion of incrementahsm (Lindblom, 1959, 1968, 1979; Quinn, 1978, 1980, 1982) in an eariier section (see section 2.2.1) the argument was that some balance was required between planning and political aspects of strategic management so that executive management could, 'avoid trying to do much while still producing plans

which commend themselves to those who must accept and implement them as a better way to develop their organisations and activities than simply applying the 'Science of Muddling Through' (Elcock, 1993: 57).

Kester (1999) also suggests that strategic plarming has limits in public service organisations because it downgrades political processes. In the political arena, many major decisions are based on political judgements, which fall prey to the illusion of objective 'scientific' decision-making (Ranson and Stewart, 1994: 188). Further Kester (1999) argue that in formulating strategic plans, clear objectives and goals are difficult to come by, since there is often no clear 'means-end relationship' (McKevitt, 1992: 36). Governments' stated policy aims are usually general and vague and even when made more explicit 'do not necessarily correspond to what government really has in mind: it may be a hidden agenda' (Baggott, 1997: 284). Kester (1999) describes one of the problems as being how can a manager know what is to be done in an environment 'where goal ambiguity is rampant' (Bozeman and Straussmann, 1990: 37).

These problems are also evident in the NHS. Elcock (1993) comments upon interminable delays by the government in preparing strategic plans in the NHS, which were accompanied by disputes over their content by the various agencies involved. This resulted in public disillusionment with the role of the state in planning public services. This combined with general public disenchantment with patemalistic professionalism, professional worries that strategic planning threatened their interest and a contradiction between uncertainty promoted by the Conservative Government from 1979 onwards yet a requirement for long and detailed strategic plans, to produce

an intellectual and popular climate of the early 1980s, in which the value of strategic planning was largely discounted (Elcock, *ibid.).* The result was a 'new incarnation of strategic management' (Elcock, *ibid:* 70), which took on board lessons learnt about these problems and combined strategic plarming with an emphasis upon strategic implementation (Elcock, *ibid.*)[12].

In assessing to what extent planning is possible, Harrison et al (1992) suggest one should look for examples of proactive behaviour from managers as evidence of this. They argue those studies of NHS planning, such as Bamard et al (1979) and Stewart et al (1980) show that proactive managerial behaviour is rarely possible. The overall picture, they argue, is one of managerial coping rather than problem solving. Harrison et al (1984) and Stewart et al (1980) view NHS managers' orientation as one focused within the organisation rather than outwards and is largely concemed with tackling problems raised by other groups of workers, and devising improved organisational formalities. They emphasise the incremental nature of any plarming undertaken by managers and argue that this allows them to avoid conflict with the medical profession. They also identify the arenas over which managers try to exert plarming influence - for example, hospital beds, shopping lists of deficiencies in existing services, or requests for resources to expand services. The domain over which managers can exert such influence and the interface with the medical profession in particular, is discussed more fully in the next chapter (section 3.4.5) and is discussed in the conclusion (section 9.2.2 (a)).

[12] Bringing debate about the utility of strategic planning up-to-date Boyne (1999) notes that the policies of the current Labour Government in the UK place renewed emphasis on rational planning in the public sector, based upon the assumption that this approach to decision-making will lead to improvements in performance. He argues that important questions remain unresolved - for example, under what circumstances does planning work best and which elements of planning are most important? Therefore,

In an empirical study that compared three case study organisations in Canada across public and private sectors, Langley stressed that strategic planning is as 'much a social process as a rational analytic process, although the form of the process varies somewhat with the type of organisation' (Langley, 1988: 49). She identifies formal strategic planning in the professional bureaucracy (Mintzberg, 1979) as problematic because it appears to make decision-making the domain of executive management. On this basis the medical group are likely to resist it. Further, in a situation where individual clinicians make strategy in hospitals, for example, by decisions about whom to treat and how to treat them, they determine in large part what the organisation will do. Hardy et al (1983) see the end resuh of such processes in a professional bureaucracy as being one of a rather fragmented process of strategy formation with the organisation's strategy typically being an aggregation of all kinds of individual and collective ones. This limits the influence of management to strategies of support, or possibly witholding support, for operating professionals' initiatives.

Mintzberg (1993) adds to criticism that managers can influence through planning activity by suggesting that the confusion of the hospital ward, for example, represents unfavourable conditions for the application of rational activity. However, despite unfavourable conditions for rational plarming, by paying attention to persuasion and negotiation, Langley (1988) is optimistic that management can influence strategic choices. She argues that strategic planning can be used as a way of bringing decisions, which used to be taken by professionals in isolation, into the domain of coUegial decision-making in which both professionals and managers had a part. Langley

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although it may be appropriate to encourage public agencies to consider carefully the potential of planning, rational processes should not be imposed upon them.

(1989) fiirther argues that 'although doctors could not be directed, they might be 'educated' through involvement in decisions and exposure to relevant information' (Langley, 1989: 620). Again in this study, as was raised in other studies (see this section 2.2.3 (a) to (c) in this chapter and section 3.4.5 in the next chapter) the power of the medical group is evident but there may be some scope for influence for management through persuasion and negotiation. However, what is stressed is that the interface between management and the medical group is a cmcial one in the realisation of strategy and that activities of the latter represent a considerable constraint upon managerial influence.

Kester (1999) provides a summary of the utility of strategic management in the NHS. He argues that, 'the how of strategic management appears to be important as the what' (Kester, *ibid:* 70) and that, 'sfrategic management sits quite comfortably if it is thought of as a process 'which helps key decision makers to think and act strategically' (Bryson, 1988: 46, cited in Kester, *ibid:* 74), rather than as purely rational plarming. However the medical group represent a considerable constraint for management in realising an influential role through strategic planning. The concept of planning, constraints upon this and middle manager influence through planning are fiirther discussed in chapter 6 at the level of the business plan. In this chapter it is evident that both the medical group and goverrunent intervention represent a constraint upon influence of middle managers in the sfrategic change process. These constraints are fiirther discussed in the next chapter (see section 3.4), which sets out policy context and the implications for middle managers.

2.3 The Role of the Middle Manager in Strategic Change

Empirical research suggests that middle managers have an upward influence upon strategic decisions (Bower, 1979; Burgelman, 1983a, 1983b, 1983c, 1991, 1994; Dutton and Ashford, 1993; Kanter, 1983; Nonaka, 1988; Sayles, 1993; Schilit, 1987; Schilit and Paine, 1987). For instance, it is posited that, 'middle managers are the only men[13] in an organisation who are in a position to judge whether [strategic issues] are being considered in the proper context' (Bower, 1970: 270). In fiirther support of upward influence of middle managers, Burgelman (1983c: 1349) points to the 'cmcial' role of middle managers in - supporting initiatives from operating levels, combining these with a firm's strengths, and conceptualising new strategies. This is confirmed in other empirical work. It has been argued, for instance, that middle managers have more of a strategic role than a purely operational role and therefore require a greater strategic orientation (Dopson and Stewart, 1990; Dopson et al 1992). Further, Dutton and Ashford (1993) describe how middle managers influence strategy through the 'selling' of strategic issues to executive management. Stewart and Fondas (1992) reinforce this view and state that, 'the greater pressures on both top and middle managers mean they need to think strategically about what they should be doing if they are to be effective' (Stewart and Fondas, 1992: 10).

Importantly, empirical research by Floyd and Wooldridge (1992, 1994, 1997; Wooldridge and Floyd, 1990) has shown a positive relationship between middle management involvement in strategy and organisational performance. Wooldridge and Floyd (1990) suggest that middle manager involvement in strategy improves

[13]The use of 'men' in this context is unfortunate. The author of this thesis wishes to point out that he does not see middle managers as solely being men. Indeed in his study most of the managers were women.

performance by improving the quality of decisions and/or increasing the consensus about strategy amongst middle managers. Thus, they argue, middle manager involvement in strategy should go beyond their traditional implementation role and that involvement should be a substantive role role rather than nominal. In later work, Floyd and Wooldridge (1997) confirm this, suggesting that, 'significant involvement in strategic decisions usefully extends beyond the top management team, and that middle manager involvement, in particular, is significant in both the definition and execution of strategy' (Floyd and Wooldridge, 1997: 482).

Further, Floyd and Wooldridge (1997) comment that:

'If the characteristics suggested by this paper are accurate, the elimination of middle managers in corporate downsizing risks damage to an organisation's process capability which might otherwise worsen, rather than improve, organisational performance (Hart and Banbury, 1994). This may have happened to Kodak, for example, when in 1988 management eliminated 12000 positions, many of them middle managers. Rather than achieving performance improvements, innovation and creativity declined and the company fell behind in the cmcial race for new products (Burris, 1994). Thus, re-stmcturing should occur with an awareness of the link between middle managers and firm competitiveness' (Floyd and Wooldridge, 1997: 482).

Of relevance to the consideration of the role of middle managers within the NHS is their suggestion that, in the face of de-layering, it is necessary to rethink the division of labour in professional service organisations, such as hospitals (Wooldridge and Floyd, 1990). They argue that middle managers with professional backgrounds are cmcial in strategic change because of their unique position between executive management and the rest of the organisation, as well as between executive management and professionals. Because of this middle managers can take on an enhanced role. It is to a discussion of what this enhanced role might be that this thesis

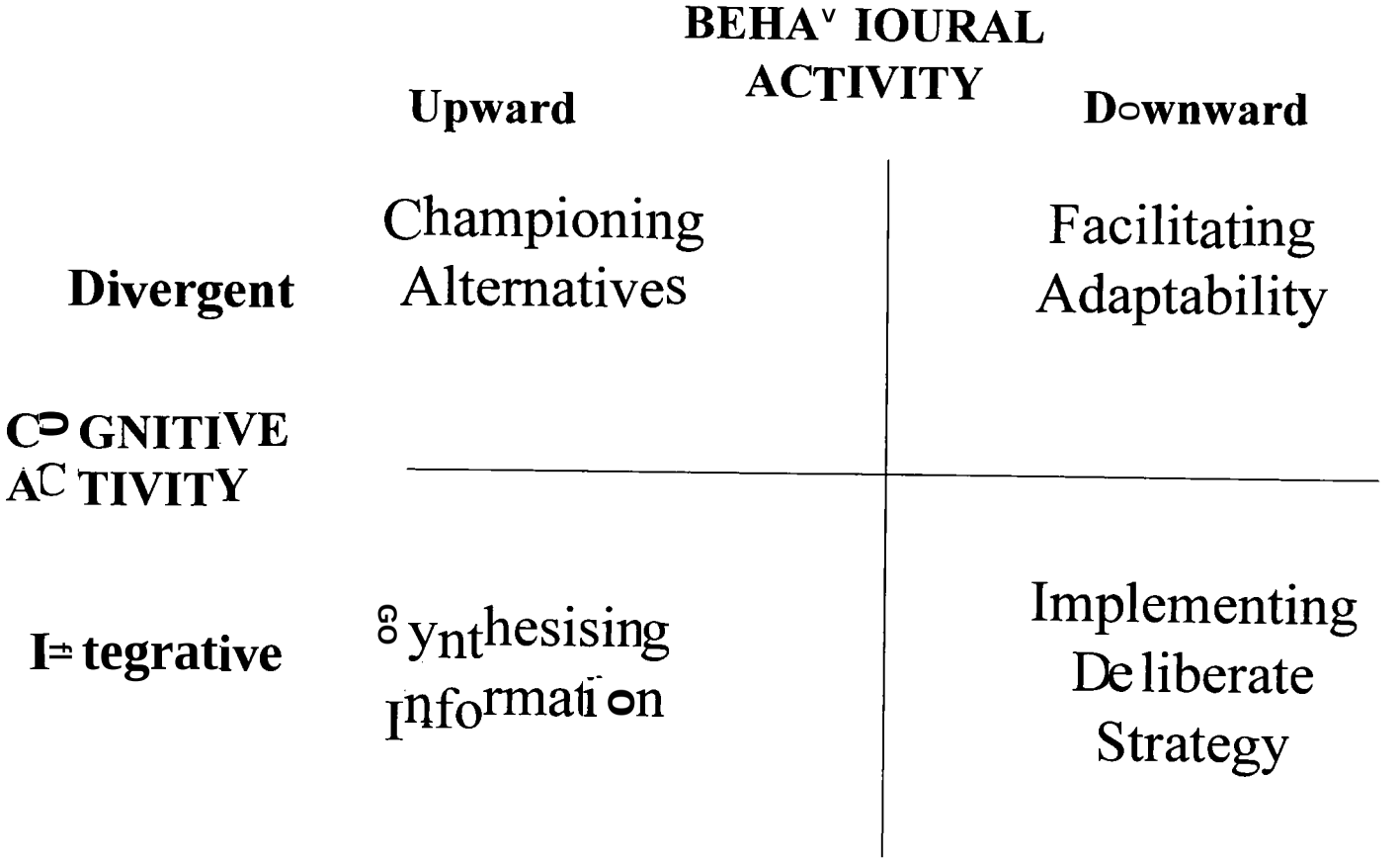
now tums. In the next section 2.3.1 a typology of middle manager involvement in strategic change, which goes beyond the role of implementation of deliberate strategy is outhned and discussed.

2.3.1 Typology of Floyd and Wooldridge

Floyd and Wooldridge (1992, 1994, 1997) premise their typology on the view that sfrategy is emergent where it is, 'a pattem in a stream of actions' (Mintzberg and Waters, 1985), and that it develops out of a continuous, interactive teaming process involving managers throughout the organisation (Mintzberg, 1990). In their work Floyd and Wooldridge (1992, 1994, 1997; Wooldridge and Floyd, 1990) lament the lack of theories or constmcts that rigorously describe middle management's strategic roles. Therefore, they follow their assertion that middle managers take on a significant strategic role by setting out a framework outlining upward and downward influence of middle managers in the sfrategic change process. This framework allows for consideration of an enhanced role for middle managers (see figure 2.3.1 on next page).

Importantly, from the four roles they describe it can be seen that middle management's involvement in strategy extends beyond providing informational inputs and directing implementation, as has been traditionally recognised, to serving as an important source of innovation in the strategy formation process. Floyd and Wooldridge (1992, 1994, 1997) describe middle management's upwards influencing activities in strategy formation as potentially altering the firm's direction by providing

Figure 2.3.1
Typology of Middle Manager Influence (Floyd & Wooldridge, 1992)



executive management with unique interpretations of emerging issues ('synthesising information') and by proposing innovative, entrepreneurial initiatives ('championing alternatives'). Such upward influence affects executive management's view of organisational circumstances (Bower, 1970; Nonaka, 1988; Dutton and Jackson, 1987).

Besides this, the downward influence of the middle manager affects the alignment of organisational arrangements with the strategic context (Nutt, 1987; Schendel and Hofer, 1979) Here we see that the more traditional role of middle managers in the 'implementation of deliberate strategy' is complemented by a potential role as change agent who foster organisational teaming. This is labelled 'facilitating adaptability' (Floyd and Wooldridge, 1997). That each of the four roles described is a synthesis of action and cognition unique to the position of middle managers provides the basis for distinctions in the typology. Hence, on one hand, a distinction in the typology is a behavioural distinction between upward and downward influence. On the other hand, whether ideas are divergent and alter the organisation's concept of strategy is distinguished from ideas that co-ordinate dissimilar activities and support a coherent direction in strategy. Although few ideas are purely divergent or integrative, recognising these two as poles of a continuum provides an appealing basis for classifying middle management's cognitive contributions alongside that of upward or downward behavioural influence which recognises middle management action contribution (Floyd and Wooldridge, 1992). Let us examine each of the roles in more detail:

2.3.1 (a) *Upward Influence*

As figure 2.3.1 suggests, middle management's upward influence activities have the potential to alter the firm's strategic course, firstly, by providing executive management with unique interpretations of emerging issues and secondly, by proposing new initiatives. In the former role of synthesising information, middle managers interpret ambiguous diverse data related to the strategic situation, framing the perceptions of other managers and changing the strategic agenda (Dutton and Jackson, 1987). In the second role of championing new initiatives, middle managers have the potential to redefine the strategic context (Bower, 1970; Burgelman, 1983a), and in so doing, reshape the strategic thinking of top management (Floyd and Wooldridge, 1992). Thus, particularly as a consequence of this latter role, as a result of middle management upward influence, strategy often unfolds or emerges differently than originally conceived (Floyd and Wooldridge, 1997).

2.3.1 (a) (i) *Championing Alternatives*

Floyd and Wooldridge (1992) assert that:

'Championing alternatives, defined as the persistent and persuasive communication of strategic options to upper management, appears to be an important middle management fiinction in strategy' (Floyd and Wooldridge, 1992: 155).

They describe its details as follows:

'Championing involves a complex sequence of activities. First middle managers act as an initial screen, selecting from the broad range of business opportunities, new process proposals, and administrative innovations suggested at operating levels. Living in the organisational space between strategy and operations, middle managers are uniquely qualified to make such judgements. Once committed, managers begin to nurture the idea, providing 'seed' resources that allow experimentation. At this stage, the endeavour lacks formal sanction, and managers' effectiveness depends greatly on their ability to get formal co-operation and support. After gaining experience and building a credible proposal, middle managers take the initiative forward' (Floyd and Wooldridge, 1994: 50).

The existence of this role of championing altematives for middle managers is also suggested by Burgelman (1983a) who reflects the role in his concept of autonomous strategy. He bases his concept of autonomous strategy upon the premise that an organisation's strategy is a combination of both 'induced' (fall within organisation's current concept of strategy) and 'autonomous' (falls outside the organisation's established concept of strategy) strategic activity. He fiirther contends that large resource rich organisations are likely to possess a pool of entrepreneurial potential at the operational-level of the organisation, which manifests itself as autonomous strategic behaviour. Here he conceptualises autonomous sfrategic activity as similar to that activity of championing altematives which is described by Floyd and Wooldridge (1992, 1994, 1997). In a further article, he contends that, 'the motor of corporate entrepreneurship resides in the autonomous strategic initiatives of individuals at the operational levels of the organisation' (Burgelman, 1983b: 241).

Kanter (1982, 1983) fiirther validates the existence of this role, whereby the innovative activity of the middle manager has the potential to alter the strategic direction of the organisation by redefining its current concept of strategy and reshaping executive management's strategic thinking. She sees middle managers as 'change masters'. She suggests that, 'because middle managers have their fingers on

the pulse of operations, they can conceive, suggest and set in motion new ideas that [top] managers may not have thought of (Kanter, 1982: 96). While, as chapter 3 outlines, financial constraints in the NHS militate against this, the potential for middle managers to take on this role is highlighted by Kanter (1982, 1983).

2.3.1 (a) (ii) *Synthesising Information*

Not all ideas charmelled upward by middle managers to executive management are necessarily innovative. Middle managers also provide executive management with information which they infüse with meaning through evaluation, advice and subjective interpretation, thereby serving as important sources of strategic issue identification (Floyd and Wooldridge, 1992).

There are a relatively large number of studies that recognise the role whereby middle managers synthesise information besides the work of Floyd and Wooldridge (Bower, 1970; Dutton and Jackson, 1987; Nonaka, 1988; Nonaka and Takeuchi, 1995; Schilit and Paine, 1987). In early work, for instance, Bower (1970) found that middle managers filter information and evaluate choices before pushing them upwards to executive management. This filtered information, in the form of strategic issues, then becomes the primary basis on which of an array of potential issues executive management then focus their limited attention (Dutton and Ashford, 1993).

Probably the most important study of a middle manager's role in synthesising information is that carried out by Nonaka (1988, 1991, Nonaka and Takeuchi, 1995). As organisational linking pins, middle managers are positioned uniquely 'to combine

strategic ... with hands on ... information' (Nonaka, 1988: 15). Having critiqued both top-down and bottom-up management as inadequate, since both top-down and bottom-up management prevents consideration of an enhanced role for middle managers, Nonaka and Takeuchi (1995) advocate a middle-up-down approach whereby the middle manager is a 'knowledge engineer'. In this approach middle managers are conceptualised as 'strategic knots' who bind top management with front line managers by synthesising and reconciling top-down and bottom-up information:

'They serve as a bridge between the visionary ideals of the top and the often-chaotic market reality of those on the front line of business. By creating mid-level business and product concepts, they mediate between 'what is' and 'what should be'. They remake reality - or to put it differently, engineer new knowledge - according to the company's vision' (Nonaka and Takeuchi: 154).

Cmcially, while this role is integrative, in that it combines ambiguous and diverse data and interprets it within a given strategic context, it may also be a precursor to the more divergent role of championing a strategic initiative. Over time the subjective interpretations of middle managers may lay the groundwork for strategic change (Floyd and Wooldridge, 1992). That this may be so is reinforced by Dutton and Duncan (1987) who posit that synergy exists between a middle manager's role of shaping the organisational strategic agenda through their interpretations of emerging issues and middle management's entrepreneurial activities. Hence, further, in later work, Floyd and Wooldridge (1994) comment:

'In conveying 'facts', middle managers may be laying the foundation for a fiiture agenda. An opportunity can be championed successfully only when all agree the 'timing is right', and usually this requires a considerable amount of prior discussion. Accordingly, middle managers are often able to control, or at least influence, top management perceptions by framing information in certain ways. This role can be

cmcial in encouraging overly cautious top management teams to take needed risks' (Floyd and Wooldridge, 1994 :50)[14].

It is worth noting that prescriptions have been offered in the literature to facilitate the synthesising role of middle managers. Many of these mainly relate to organisational sti-ucture. In particular, such prescriptions talk of a need for middle managers to boundary-span if they are to take on an enhanced role. For instance, following the assertion that middle managers are the 'knowledge engineers' in an organisation Nonaka and Takeuchi (1995) prescribe a 'hypertext organisation'. They assert that a hypertext organisation stmcture enables an organisation:

' ... to create and accumulate knowledge efficiently and effectively by transforming knowledge dynamically between two stmctural layers - those of the business system, which is organised as a traditional hierarchy, and of the project team, which is organised as a typical task force. The knowledge generated in the two layers is then re-categorised and re-contextualised in the third layer, the knowledge base' (Nonaka and Takeuchi, 1995: 193).

Putting aside debate about whether this is an appropriate organisation stmcture compared to any other advocated, the important issue raised here is the concept of boundary-spanning. This has been acknowledged by many researchers as leading to influence in the strategy process (Jemison, 1984; Brass, 1984; Leifer and Delbecq, 1978; Tushman and Romanelh, 1983). Tushman and Romanelli (1983) describe three distinct types of boundary-spanning roles carried out by individuals - those who span intra-organisational boundaries, those who span extra-organisational boundaries and those who span both boundaries. That those middle managers that span boundaries

[14] In considering this within a NHS context, this thesis draws attention to an observation within the Griffiths Report (DHSS, 1983), described in chapter 2 of this thesis. This described the NHS as, 'structured to resemble a mobile; designed to move with any breath of air, but which in fact never changes its position and gives no clear indication of direction' (general observations, para. 8: 12). Thus, as well as encouraging risk-taking, the issue of conservatism on the part of middle managers that discourages risk-taking should also be considered. It may be that middle managers can use the synthesising information role to influence strategy formulation so that it remains conservative or modify the implementation of deliberate strategy because they wish things to remain the same. Wall (1999) identifies this as a potential problem, particularly where middle managers have come up through the ranks, where 'cultural rigidity' (Handy, 1985) may be exhibited in the conservatism of middle managers.

will exert more upward sfrategic influence in particular than non-boundary-spanning managers is an important finding in the work of Floyd and Wooldridge (1997). Specifically their study showed that a middle manager's strategic influence arises from their ability to mediate between internal and extemal selection environments, i.e. their boundary-spanning role.

This finding is validated in other work (Astley and Sachdeva, 1984; Jemison, 1984). For example, Astiey and Sachdeva (1984) argue that the information mediation role of boundary-spanning individuals creates dependencies, which serve as the source for intra-organisational influence. Similarly, Jemison (1984) suggests that boundary-spanning equips particular individuals with the ability to deal with strategic contingencies.

However, only some fimctions may be boundary-spanning. Specifically, Floyd and Wooldridge (1997) define these as marketing, purchasing and human resource management. They define others, such as finance, accounting, operations and quality control as non-boundary-spanning[15]. The important issue is a suggestion in the work of Floyd and Wooldridge *{ibid.)* that middle managers in non-boundary-spanning fimctions are less likely to exert upward influence. This is of consequence since this thesis focuses upon those middle managers that work in the individual clinical directorates, i.e. non-boundary-spanning operational managers. They are therefore less likely to be able to take on the enhanced role that is called for by those who are optimistic about the future of middle managers. This brings us back to those

[15] In this distinction, quality control is a non-boundary-spanning function. Perhaps this reflects a narrow definition of quality control since, in the NHS, quality initiatives more generally, lend themselves to boundary-spanning opportunities for middle managers. For example, within the NHS, the process of gaining Kings Fund accreditation[15] may provide boundary-spanning opportunities for middle managers. Professional bodies at a national level, such as the College of Radiotherapy, may also be used as a resource to improve quality by middle managers and provide an opportunity for boundary-spanning. Another example is the

organisational prescriptions that call for stmctural change. Restmcturing of organisations so that middle managers can take on boundary-spanning roles may facilitate middle manager's upward influence. This point will be returned to in the next sections and towards the end of this thesis in section 9.2.3 (a).

2.3.1 (b) *Downward Influence*

With downward influence, middle managers become change agents, facilitating adaptability and implementing deliberate strategy. The former facilitating role stimulates development in others and promotes learning, increasing the ability of members to respond to change (Nonaka, 1988, 1994). In the implementation role, middle managers engage in an ongoing set of interventions to bring organisational action in line with deliberate strategy (Nutt, 1987; Sayles, 1993; Schendel and Hofer, 1979).

2.3.1 (b) (i) *Facilitating Adaptability*

Floyd and Wooldridge (1992, 1994, 1997) define facilitating adaptability as, 'fostering flexible organisational arrangements'. They illusfrate the role of facilitating adaptability using Kanter's study of an employee involvement programme (Kanter, 1983). Here middle managers sheltered and encouraged an employee involvement programme in the midst of top-down change aimed at redesigning the production processes. In doing this, the process diverged completely from top management's original intention. Floyd and Wooldridge (1992) agree with Kanter (1983) that the

increasingly popular route taken by trusts for Investors in People" accreditation, which again may involve middle managers in boundary-spanning activities to improve quality.

proposed re-engineering could have failed without the middle management's efforts to facilitate change and that middle managers are better described as 'change masters' rather than 'change resisters'.

Floyd and Wooldridge (1992, 1994, 1997) contend that middle managers nourish adaptability which lies outside the plan embedded in deliberate strategy, or sometimes in spite of the plan (Bower, 1970; Kanter, 1983). Middle managers harbour and sponsor 'radical' interpretations, approaches and sense-making activities that fall outside the organisation's official expectation. Thus, they are stimulators of emergence in strategic change. That this is so is validated by several qualitative studies beyond those cited above (see also Burgelman, 1983a; Kidder, 1981).

Again in terms of prescriptions to allow this role to flourish, restmcturing is advocated. For example, Floyd and Wooldridge (1994), in order to reflect an appropriate organisational stmcture, which allows for an enhanced role for middle managers, use the metaphor of a 'flexible, accordion-like stmcture of a reticulated passenger bus. The shape and composition of the accordion overcomes the rigidities of the vehicle, while at the same time assuring that the front and back head in the same direction' (Floyd and Wooldridge, 1994: 51). Other studies also advocate restmcturing. Variously it is argued that matrix stmctures, task forces, dynamic networks and simple informality increases information sharing (Kanter, 1983; Miles and Snow, 1986; Mintzberg, 1979), which in tum facilitates organisational learning (Floyd and Wooldridge, 1992).

In the context of the NHS, that networking may be embedded in the restmcturing is relevant. For example, the context of the recent White Paper, *The New NHS: Modern and Dependable* (DoH, 1997), encourages the development of collaborative multi-agency healthcare provision. Therefore it draws attention to the development of inter-organisational and intra-organisational networks in doing so. In the strategy literature this idea is not a new one although attention has been focused on the private sector. Miles and Snow (1986) talk of fiiture forms of organisation as featuring some of the properties of the 'dynamic network form', particularly heavy reliance on self-managed workgroups and a greater willingness to view organisational boundaries and membership as highly flexible. If dynamic network organisational forms are one outcome of the recent NHS reforms, then such restmcturing may allow an enhanced role for middle managers (see section 9.4.4).

Feriie and Pettigrew (1998) examined the emergence of the network organisation in the NHS. While their focus is upon purchasing organisations and, 'reflects practice as it is evolving at its leading edge' (Ferhe and Pettigrew, 1998: 208), they make some interesting points that are relevant to the focus of this thesis. They assert that the NHS has moved from being a vertically integrated organisation with a strong general management spine (1983-1990), through to being a mature intemal market that encourages relational contracting (1991 onwards), towards being a new network-based agenda (from mid-90s onwards). While they ask whether network management is merely a faddish phase for the centre, their view of networking suggests that middle managers are likely to lose out with the emergence of networking organisations, rather than gain through being re-positioned as boundary spanners. Thus, while the research took place at a time prior to the recent reforms being implemented, the

emergence of collaborative multi-disciplinary, multi-agency organisation of healthcare delivery, as part of the recent reforms, will be considered and some comment will be made towards the end of the thesis as to the potential impact of the reforms upon middle managers (section 9.4.4).

2.3.1 (b) (ii) *Implementing Deliberate Strategy*

Implementation of executive management's strategy is often considered the key strategic role of middle level managers (Nutt, 1987, Schendel and Hofer, 1979) and the purpose is to control performance with respect to the desired ends of executive management (Hrebiniak and Joyce, 1984). This contrasts with championing, facilitating, and in some cases, synthesising, where middle managers go beyond, or even ignore, the plans embedded in top management's deliberate strategy. However, it should be recognised that even in the most deliberate contexts strategies are modified to incorporate new information as it presents itself (Quinn, 1980). Thus it is not, as is commonly misconceived, a mechanical process. Instead it is best characterised as an ongoing series of interventions which are only partly anticipated in executive management plans and which adjust strategic direction to suit emergent events (Floyd and Wooldridge, 1997). This role is an integrative one since it links organisational action-taking throughout the lower echelons of the organisation with executive management intentions (Floyd and Wooldridge, 1992).

That this is a commonly recognised strategic role is shown in other studies (Nutt, 1987; Quinn, 1978, 1980, 1982). For example, in his description of and prescriptions for strategic change via logical incrementahsm, Quinn (1978) sees the implementation

of deliberate strategy as a series of ongoing actions, which align organisational action with deliberate strategy. In this role, middle managers translate strategic objectives into shorter-term 'operational foci of behaviour' (Hrebiniak and Joyce, 1984: 107) and a certain degree of uniformity is required to achieve horizontal consistency at operating levels. Without consistency, co-ordination breaks down among the various elements of strategic change. Inconsistent levels of downward influence from middle managers in this role may exist because of middle manager resistance to deliberate strategy. This may hamper the overall realisation of strategy and may be an important influence upon strategic change that executive management wish to control.

While, as mentioned in the previous chapter, middle managers in the NHS have been neglected in the literature, the small amount of literature analysing the role or experiences of middle managers in the NHS has tended to emphasise this role of implementing deliberate strategy. For example, Feriie et al (1996) talk of a 'hybrid manager' who sits on the boundary between professionals and managers, 'forming an important bridge, who both represents the professional agenda and embodies its disciplining by a managerial one' (Ferhe et al, 1996 :194). Imphcit in this description of the hybrid manager is that implementation of deliberate strategy may represent their major role. This is emphasised to a greater extent in the more practitioner-orientated work of Wall (1999). Wall, borrowing from Jacques (1976), describes middle managers as, 'typically the co-ordinators. They take messages from senior and top managers and convert them into operational work, making sure that the various components fit with each other' (Jacques, 1976: 23). Later, he adds, 'failure to do this means that what managers at the top decide is never effectively implemented as the

shop floor subverts the organisation for their own ends ... using their own experience they [middle managers] ... manage meaning' (Jacques, 1976: 24-25).

2.4 Facilitating a Fuller Contribution from Middle Managers

Apparent from the discussion so far in this chapter is that a great deal of work, including that of Floyd and Wooldridge (1992, 1994, 1997; Wooldridge and Floyd, 1990), suggests that significant involvement in strategic change may usefiilly extend beyond the executive management team, and that middle management involvement, in particular, is significant in all aspects of strategic change. Their work stresses the importance of inclusiveness, particularly of the middle management group, as a feature of sfrategic change (see also - Burgelman, 1983b; Dutton and Ashford, 1993; Hart, 1992; Mintzberg, 1978).

In particular, in order to facilitate inclusiveness, much research advocates change in organisation stmctures since only a fraction of middle managers are positioned to become influential in the strategic process. In Floyd and Wooldridge's study (1997), for instance, only about one quarter of middle managers were in the boundary-spanning positions, which allowed for an enhanced role. To improve the positioning of middle managers to take on an enhanced role, Floyd and Wooldridge (1994) advocate that organisations, 'move away from hierarchical toward more horizontal business structures' (Floyd and Wooldridge, 1994: 53). They set out principles which executive managers should consider in re-engineering the de-layered organisation yet at the same time leveraging the contributions of the middle management resource.

Important amongst these is that middle managers should be identified with boundary-spanning experience (and implicit within this that they are kept rather than made redundant). Secondly, executive management need to analyse the changed role of middle management and begin to develop it within the organisation. Floyd and Wooldridge (1994) highlight the contribution of human resource strategy, with a particular emphasis upon organisation development and management development, towards this. In addition attention is drawn to a redistribution of power in the new arrangements, which results from a need for process-oriented, horizontal logic since, until now, 'senior managers expect middle managers to take charge of a process but give them little real authority' (Floyd and Wooldridge, 1994: 54). They fiirther assert that middle managers need room to experiment if their potentially enhanced contribution is to be realised. As a result, if their contribution is recognised and valued by executive managers, middle managers should enjoy a renewed sense of power.

The prescriptions which Floyd and Wooldridge offer are reflected in studies by other academics. For example, in describing and analysing the role of middle managers, that organisation restmcturing along horizontal process-oriented lines is important, is home out by many others (Astiey and Sachdeva, 1984; Jemison, 1984; Nonaka, 1988; Nonaka and Takeuchi 1995). In chapter 1 of this thesis, in support of the optimistic commentary about the fiiture role of middle management despite decreasing numbers, prescriptions were outlined to encourage a full enhanced contribution from middle managers (Evans, 1992; Frohman and Johnson, 1993; Kanter, 1982, 1983; Nonaka and Takeuchi, 1995). It was promised that these would be elaborated upon in this chapter. In particular it is worth dwelling on the contributions two of these writers in considering ways forward for enhancing the middle manager's role - Frohman and

Johnson (Frohman and Johnson, 1993; Johnson and Frohman, 1989) and Kanter (1982, 1983). As well as stmctural prescriptions, both writers emphasise the importance of human resource policies and practices in encouraging an enhanced role for middle managers.

Rosabeth Kanter is probably the best known of the advocates of an enhanced role for middle managers and characterises them as 'changemasters' (Kanter, 1983). In support of a potentially more optimistic reading of fiiture middle manager roles, she identifies corporate conditions which encourage enterprise from middle managers:

'What makes it possible for managers to use such skills [enterprise, innovation, entrepreneurship] for the company's benefit? They work in organisations where the culture fosters collaboration and teamwork and where stmctures encourage people to 'to do what needs to be done'. Moreover, they usually work under top managers who consciously incorporate conditions facilitating innovation and achievement into their companies' stmctures and operations' (Kanter, 1983: 96).

As previously commented upon, financial consfraint in the NHS context makes the changemaster role for middle managers less likely. Under these conditions executive management may take a narrow viewpoint and disregard irmovation from middle managers as potential source of efficiency gains. However, the general point is raised that there is potential for such a role even if it is limited in the NHS context. In which case note should be taken of conditions that create opportunities and incentives for middle managers to go beyond their formal jobs and combine organisational resources in new ways. Thus, Kanter (1983) assert, following a study of 165 'effective' managers, that the following conditions allow for a changemaster role - multiple reporting relationships, a free and somewhat random flow of information, many centres of power with some budgetary flexibility, a high proportion of managers in

loosely defined positions or with ambiguous assignments, frequent and smooth cross-functional contact, a tradition of working in teams and emphasis upon lateral rather than hierarchical relationships, and finally, a reward system that emphasises investment in people and projects rather than payment for past services. She fiirther contends that these conditions can be designed into older, traditional organisations as well as less mature organisations.

In support of this, Frohman and Johnson (Frohman and Johnson, 1993; Johnson and Frohman, 1989) are concemed that middle managers rise to the challenge of new roles and responsibilities so that the 'gap' that exists in the middle of many organisations is closed. They advocate that organisational stmctures and procedures be changed so that a more 'balanced' organisation is created whereby two important lateral dimensions for middle managers are added. The first is a horizontal or lateral dimension inside the organisation, flattening the walls of the old 'up-down' firm that had separated one department from another. The second is the creation of networks outside the organisation, spanning traditional boundaries to improve access to new technology and to develop better communication and collaboration with supphers and customers. Thus again there is an emphasis upon stmctural change in organisations to realise the full potential of the middle manager contribution. Specifically, the following stmctural elements are prescribed, based on empirical findings - cross-functional operating teams, lateral project and new-product teams, rotation of middle managers across departmental barriers, cross-functional fomms of middle managers, and human resource systems that support and value lateral contributions of middle managers (Frohman and Johnson, 1993).

However, the most important suggestion in the literature, which sets out conditions for an enhanced role for middle managers in the realisation of strategic change, is that an enhanced role may be a product of involvement of middle managers in strategic change so that there are elements of emergence alongside deliberateness. This was discussed earlier in this chapter and some questions raised about the balance between the different elements of strategic change - that is, top-down rational planning and politics - as well as the balance between allowing for emergent strategy and ensuring confrol through deliberate strategy.. It will now be elaborated upon in chapter 3 by examining policy changes in the NHS, particularly that since 1983, the year in which a raft of reforms, which promoted general management in the NHS, were launched by the previous Conservative administration.

2.5 Conclusion

The typology described by Floyd and Wooldridge (1992, 1994, 1997) can be used to address the question rehearsed in chapter 1 that asks if middle managers are likely to enjoy an enhanced role in the fiiture or one that is significantly reduced. In this thesis the question is addressed within a specific context - that of the NHS - hence meeting a call for more empirical research (Dopson and Stewart, 1990). In doing this it will explore the validity of the typology of middle managers involvement in strategic change set out by Floyd and Wooldridge *{ibid.)* and explain variations in roles. Wooldridge and Floyd (1990) emphasise that future research should focus upon questions like, 'what are the organisational conditions that facilitate/inhibit strategy involvement by middle managers' (Wooldridge and Floyd, 1990: 239). Later, Floyd and Wooldridge (1992) call for context-specific research, which will:

'investigate contingencies that affect how middle managers contribute to strategy. In particular, future studies should examine involvement in various environmental and competitive settings' (Floyd and Wooldridge, 1992: 166).

Therefore, the importance of irmer and outer contexts of strategic change at organisation level will be considered.

Firstly, the strategic context in which middle managers carry out their role will be examined. The impact of characteristics of strategic change upon the middle manager role in strategic change will be analysed using the literature, which was outlined in the earlier part of this chapter. Of particular interest in investigating the impact of the characteristics of strategic change upon the role of middle managers is the balance between deliberate and emergent strategic change. The typology of Floyd and Wooldridge (1992, 1994, 1997), which has been described above, fits well with the view that strategy is emergent and can contribute towards our understanding of how executive management intent combines with middle management activity in the creation of realised strategy. As Floyd and Wooldridge (Wooldridge and Floyd, 1990) themselves assert, their view challenges the traditional division of labour in strategic change and suggests new roles in the strategic process. While executive management defines the strategic context and provide broad direction, middle management are in a better position to initiate and assess altemative courses of action.

Secondly, the influence of centre-periphery relations upon the role of middle managers will be considered - that is, the relationship between executive management at the corporate centre with middle managers in the operational directorates. At the level of outer context, this question of cenfre-periphery relations will be extended, to

investigate the influence of the way in which the DoH and the NHSME develop and implement policy upon the role of middle managers. That this may be an important influence is elaborated upon in the next chapter, where the effect of government intervention upon discretion for middle managers in NHS organisations at the periphery, is highlighted. As an additional constraint, given the difficulties of realising change in a professional bureaucracy (Mintzberg, 1979, 1985), the impact of the medical group upon middle manager roles will be considered in more detail.

An important question, in considering centre-periphery relations, is one of how much control should be surrendered by executive management to those who are closer to the operational situation who have the information current and detailed enough to shape realistic sfrategies - that is, middle managers. Therefore, In particular the impact of different approaches to strategic change for the role of middle managers will be investigated.

Thirdly, those stmctural contingencies, which inhibit or facilitate a fuller contribution from middle managers towards strategic change, will be noted. Such stmctural contingencies will be compared to prescriptions offered, not just by Floyd and Wooldridge (1997), but other conunentators. Given that much of the emphasis in these studies is that there is a need for boundary-spanning on the part of middle managers (for example, Nonaka and Takeuchi, 1995) this thesis will seek to illustrate instances of this. In addition, note will be taken of organisation development and management development, which support an enhanced role for middle managers, in the light of its importance which has been highlighted by some commentators (for example, Kanter, 1982: Frohman and Johnson, 1993).

Finally, context will also be considered as a political issue where it is not an 'objective, inert entity' but one that can be mobilised and who's meaning can be managed to create legitimacy for change attempts (Pettigrew eLal, 1992). Thus, the thesis will consider how context is mobihsed to establish legitimacy, not only for executive management, but also for middle managers change attempts or where middle managers resist change.

To summarise, this thesis will investigate the following in particular -

(1) Middle managers roles in the NHS context - using the typology set out by Floyd and Wooldridge (1992, 1994, 1997) what roles they take on and whether their role has been enhanced or reduced since the inception of general management reforms, discussed in the next chapter, in 1983.

(2) Characteristics of strategic change that facilitate or inhibit an enhanced role for middle managers in the NHS - in particular, the balance between deliberate and emergent sfrategic change, the extent to which strategic change is separated into a formulation and implementation stage and the balance between top-down rational planning and a pohtical element of strategic change (Whittington, 1993).

(3) The influence of centre-periphery relations and the medical group upon the role of middle managers in the NHS - in investigating cenfre-periphery relations, firstly, how much control should be surrendered by executive management at the cenfre to middle managers at tmst level so that operational context is taken account of Secondly, at the

level of outer context how does the way in which the DoH or NHSME develop and implement policy influence middle manager's roles.

(4) The existence of supporting mechanisms for an enhanced role for middle managers - in particular, stmctural contingencies and investment in organisation development and management development, which inhibit or facilitate a fuller contribution from middle managers towards strategic change.

Before, considering these questions empirically through the case studies set out in chapters 5 to 8, the next chapter will discuss the NHS policy context in which the middle managers role is placed. Drawing upon literature about the impact of policy in the NHS, particularly since 1983, some potential issues will be fiirther highhghted for the role of the middle manager in strategic change.

Chapter 3

The Role of Middle Managers in the NHS

3.1 Introduction

The apparent lack of consensus in the debate about the fiiture of middle managers, discussed in chapter 1, has led to calls for more empirical studies, particularly ones that shed light on industry and organisation-specific developments. Studies of middle management may need to recognise, much more clearly, the difference between public and private sector organisations in considering the reaction of middle managers to strategic change and the role they subsequently take up in the realisation of strategic change. As Dopson and Stewart comment:

'There is no attempt to differentiate between the future of middle management in different organisational contexts. It may well be that the work and situation of middle managers in the public sector is very different from that of their counterparts in a traditional industry or newer industries (Dopson and Stewart, 1993: 15).

Dopson eLal (1992) view the public sector as particularly interesting in considering the role of middle managers since middle managers in this sector may see themselves primarily as professionals. Public sector managers may view opportunities for an empowered role, which change may provide, as a poor substitute for an attack upon identity and loss of traditional career progression (Thomas and Dunkeriey, 1997). Dopson and Stewart (1992) fiirther argue that the learning of new skills and vocabulary associated with change was more difficult for middle managers in the

public sector than in the private sector because of their professional backgrounds. This gives rise to greater resistance, particularly where change was viewed as 'ideological', as the market-driven reforms might be perceived, rather than necessary for more efficient and effective healthcare delivery and where changes were seen as overly mimicking the 'commercial' world.

Feriie et_al (1996) also argue that public and private sectors differ and that the public sector can be broadly seen as a family of organisations that contain important similarities and are experiencing common pressures. Most notably, there is increasing central intervention from government and this is accompanied by central control from executive management so that government requirements are met. This has led to some questioning of claims that middle managers in the public sector are being empowered (Famham and Horton, 1996). Further, it is claimed that the trend towards downsizing and restmcturing is likely to lead to shake-outs of middle managers right across the public sector, so that threats to job security amongst middle managers, across the public sector, 'reached new heights of intensity' (Famham and Horton, 1996: 269).

In relation to the typology of Floyd and Wooldridge (1992, 1994, 1997), it may be that middle managers may be reluctant to take on opportunities for an enhanced role because of the professional values held by them. In addition, they may also be inclined to resist strategic change in their role in the implementation of deliberate strategy.

On one hand, there appears to be competing tensions raised in the literature about the experience of middle managers in the public sector, that are similar to those raised more generally in the literature outlined in chapter 1. On this basis, it may be argued

that the public sector is not as distinctive as some claim. On the other hand, there is a distinctive policy context in the UK public sector that generates such tensions and suggests that the public sector should be considered separately from the private sector. The question of similarity or difference between public and private sectors is retumed to in the conclusion, when discussing the generalisability of the findings (see section 9.3).

The first part of this chapter tums to the distinctive policy context that provides a backdrop to the role of middle managers in sfrategic change. This briefly outlines New Public Management (NPM) (Feriie et al, 1996) as a coherent body of policy initiated by the previous Conservative administration. Following this brief overview, the focus lies with the NHS specifically. Firstly, there is a historical overview of NHS policy. This concentrates mainly upon those policy changes since 1983, but includes some commentary relating to policy prior to this, since there is evidence of continuity as well as change between these periods. In the second part of the chapter, literature is reviewed that provides commentary about the impact of this policy upon the role of the middle manager in the NHS.

3.2 New Public Management

Feriie et al (1996) set out a usefiil typology of New Pubhc Management (NPM) ideal types, which provides the policy backdrop to strategic change in the public sector. Under NPM model 1- the 'efficiency drive'- there is a stronger general managerial spine with a shift in power from professionals to management and there is some empowerment of less bureaucratic and more entrepreneurial management. However,

even here, the public sector is diagnosed as bloated, wasteful, bureaucratic and underperfonning, thus providing a hint those managers themselves would come under scmtiny. In NPM model 2 - the 'downsizing and decentralisation' model - some of the eariier changes in the first model are undermined. These spring from the more general organisational trends discussed in chapter 1, such as downsizing and decentralisation. Feriie et al *{ibid.)* see this model as being increasingly significant and including a drastic reduction in the payrolls of public sector organisations with flatter organisational stmctures and a move from management by hierarchy to management by contract. Another important strand of the reforms is represented by a third NPM model - 'in search of excellence'- where there is a strong emphasis upon the management of organisational culture. The role of middle managers is not clear in this but taking a lead from aspirations of the Griffiths Report *{ibid),* to some extent middle managers take the role of 'change agents'. [16]

In terms of the models described by Feriie et al (1996), NPM1 (the 'efficiency drive') and NPM3 (the 'search for excellence'), operated from the time of the Griffiths Report in 1983, which promoted general management in the NHS. The introduction of general management and the intemal market, which are both considered in the next section of this chapter (section 3.3), appeared to strengthen the role of management in the NHS. As part of this, the balance between bureaucratic control at the centre and discretion for middle managers to respond to local problems was expected to move in favour of the latter as responsibility was pushed down the line. Only from 1992 onwards was NPM2 - downsizing and decentralisation - fully in evidence when financial constraints meant that middle managers saw attacks upon their numbers in

[16] Feriie et al identify a fourth model - 'public sector orientation'- which they state to be less developed than the other three. Given the time period, which was one where such an orientation was less developed, over which this thesis focuses, this is not

the NHS. Thus, it appears that the fortune of the middle manager has waxed and waned over the period of the Conservative Government administration although this is not fully captured in the typology set out towards the start of Feriie et al *{ibid).* The next sections 3.3 and 3.4 of this chapter will discuss these NPM trends in more detail and specifically focus upon the NHS when considering their impact upon middle managers.

3.3 Policy Change in the NHS

It is not necessary for the purposes of this thesis to give a detailed account of the development of the formal organisation of the NHS from its creation in 1948 until the appearance, in 1983, of the Griffiths Report (DHSS, 1983). Such an account can be found in Klein (1995). However, it is worth stressing that there is an underlying continuity as well as significant change.

Harrison et al (1992) draw attention to five elements in this continuity. First, control over the overall level of finance going into the NHS has remained firmly with the central government throughout the period of the NHS. Secondly, although under its constituent legislation, the Secretary of State had a statutory duty to provide a NHS, he or she exercise this through statutory bodies acting as agents in mnning the service - for example, Health Authorities. A third element of continuity is the close relationship, at national level, between the government and medical profession. The fourth element of continuity is that, at local level, formal organisational arrangements have been so designed as to leave doctors (GPs and hospital consultants) free from

described as a feature of context in this chapter. However, there is some consideration of an emergent 'hybrid' manager, which stems from this, towards the end of this thesis.

day to day management, and to leave members of other clinical professions managed only by other members of their own profession. Fifthly, there has been an obsession with organisational formalities as the key to better management. More precisely, there was a dominant assumption in the 1960s and 1970s that the improvement of inputs into management, such as career stmctures, job specialisation, education and systems, such as planning, was a sufficient condition for improved results.

It is this fifth element of continuity identified by Harrison et al (1992), which is of most relevance to this thesis. To appreciate recent events in the NHS and to put them in a historical context it is useful to describe attempts prior to the Griffiths Report (DHSS, 1983) to ensure better management. An important central intervention in the relation to the thesis was that of the Salmon Committee (Ministry of Health & Scottish Home and Health Dept., 1966), which recommended a division between nurse managers and nurse practitioners. Nurse matrons who combined professional and managerial leadership were to be replaced by a hierarchy of nurse managers. Thus, management became a specialist fiinction in its own right. There were three levels of nursing management. The executive managers were concemed with the making of policy while the middle and first-line managers were responsible for its execution. Thus, the Salmon Committee effectively invented middle management in the NHS following their reconunendations that nursing should be re-organised (Allsop, 1995).

The next significant re-organisation, in the light of the research question posed in the thesis, was the re-organisation of the NHS in 1974. 'Consensus management' underiay the new stmctural arrangements. The consensus management group, in

which there was to be no hierarchy, comprised an administrator, a treasurer, one or more doctors and a nurse. Under consensus management, the management group was vested with a collective authority to take decisions and enjoyed a corporate existence and responsibility (Harrison et al, 1990). Such consensus management arrangements were a political exercise that tried to satisfy everyone and to reconcile conflicting policy aims. For example, consensus management sought to promote managerial efficiency but also to satisfy the professions and to create an effective hierarchy for fransmitting national policy but also to give scope to managers at the periphery (Klein, 1995). As further discussed in section 3.5.1 under consensus management the role of the middle manager was very limited.

Such consensus management arrangements reflected a fimdamental tension between the centre and the periphery of the NHS that derives from the organisational form of the NHS when it was set up in 1948. Firstly there was a bargain stmck in 1948 between the state and medical profession whereby financial power was concentrated at the centre and clinical power concentrated at the periphery. Thus the medical profession had to ration service provision operating within a limited budget set by government but the goverrunent had little control over how resources were utilised (Klein, 1995). In response to this bargain, governments have altemated between periods of centralisation, in order to gain control, followed by a decenfralising reaction against the rigidities which are caused as a consequence (Ranade, 1997).

This tension, between the centre and periphery of the NHS, provides the backdrop to the management 'problem' in the NHS, the quest for a more efficient and effective organisational stmcture and managerial control strategy. This has formed the basis of successive reforms of the service, including the Griffiths Report (DHSS, 1983) in 1983 (Clark and Starkey, 1988; Harrison et al, 1990; Allen, 1996), which initiated the set of reforms that provide the backdrop to this study. The influence of centre-periphery relations are illustrated in the empirical cases and discussed fiirther in the concluding chapter (see section 9.2.2(b)). However, it is to a description of the Griffiths Report that the thesis now tums.

3.3.1 The Griffiths Report and General Management

Around the time of the Griffiths Report (DHSS, 1983) one of the Conservative administration's highest priorities was to contain and reduce levels of public spending. At the time the DHSS appeared to lack sufficient grip on the NHS and health authorities appeared to be insufficiently accountable to ministers (Harrison et al, 1990). Thus, the DHSS through the Griffiths Report changed the relationship between the centre and the periphery in favour of the former. The implicit understanding adopted back in 1948 that professional sensibilities and freedom were not to be disturbed was no longer regarded as sacrosanct. At the top, within the DHSS, there was to be a Supervisory Board to be chaired by the Secretary of State, to set objectives, take strategic decisions and receive reports on performance. Below that, but still within the Department, there was to be a Chief Executive, to carry out the policy objectives, provide leadership and control performance. Lastiy, and perhaps most importantly, Griffiths introduced general management further down the NHS

organisational stmcture and created general managers who were responsible for the operations of the NHS at all levels - regions, districts and units (Klein, 1995).

An important assumption of the Griffiths Report (DHSS, 1983) was that public and private sector were largely similar. As a manifestation of this belief in general management and that private and public sectors were similar, the Griffiths Report *{ibid)* intended that large numbers of the new general management cadre would be recmited from the private sector and that strategic change would utilise models of organisational and managerial practice imported from the private sector. On one hand there is some support for the generic transfer of managerial ideas and practices from the private to public sectors (Pettigrew et al 1992). However, on the other, while Pettigrew et al *{ibid.)* are generally supportive of generic transfer, even they admit that similarities and differences between the two sectors need to be dis-aggregated in finer detail. Further they argue that, while up to the mid-1980s the dominant problem was one of parochialism and isolation within the public sector, since then the difficulty has been an over-mechanistic transfer of concepts from the private to the pubhc sectors.

To its critics general management reflects an inappropriately imported model of private sector management that takes no account of the distinctive properties of pubhc sector organisations (Ackroyd et al, 1989, Hood 1991, PoUitt 1990, Stewart and Walsh 1992). For example, Stewart and Ranson (1988) argue that the main reason that decision-makers should be alert to the dangers of mechanistic fransfer from the private to the public sector is that resource allocation in the public sector, unlike that in the private sector, is an intensely political process.

Finally, some academics take a stance between the two extremes and develop a public management approach which is more open to generic theory, while still alert to the dangers of mechanistic transfer from the private to the public sector - the 'Public Sector Orientation' model (Stewart and Ranson, 1988). Pettigrew et al (1992) pick up on this and argue that the problem may be not that of generic transfer per se but of generic transfer of highly prescriptive, formalistic managerial ideas and practices from the private sector.

The Griffiths Report (DHSS, 1983) focused upon organisational culture and cultural change[17] in promoting a general management ethos in the NHS (Allsop, 1995; Feriie et al, 1996; Harrison et al, 1989), which was allied to the new stmctural arrangements. In aspiring to manage culture, Griffiths cast a new cadre of general managers as 'change agents'. This was evident in documentation subsequent to the Griffiths Report, where a statement was made that, 'the Health Service Managers of today are in a new and important sense leaders of the organisation and custodians of its values and standards' (NHSTA, 1986, cited in Pettigrew eLal, 1992: 21). This is further elaborated upon in section 3.4.2 when discussing the imphcations of the Griffiths Report for middle managers.

3.3.2 Working For Patients and the Internal Market

It should be emphasised that the Griffiths Report (DHSS, 1983) was only a beginning of reforms initiated by the Conservative Administration (1979-1997). Following Griffiths, in 1989, the Prime Minister's Review of the NHS, *Working for Patients*

[17] As footnoted in section 2.2.2(b) the intention in this thesis is not to focus upon culture as a sensitising device. Instead the thesis is concemed with the influence of characteristics of strategic change more generally, such as whether it is deliberate or emergent.

(WPf) was published (DoH, 1989a). Together with the parallel changes to community care planned by the government, the proposals in WfP were incorporated in *The NHS and Community Care Act* (DoH, 1990). The legislation paved the way for an intemal market to come into operation in the NHS in April 1991. The purchasing of health care was to be carried out by the district health authority and/or local GPs organised into fundholding practices whilst healthcare was to be provided by hospital, community healthcare and mental healthcare 'trusts'[18]. The government proposed in the WfP White Paper to maintain the public financing of the NHS but on the supply side of health care, the intemal market was to create greater efficiency through increased competition.

Of relevance to this thesis is that WfP reforms represented 'emergent' sfrategy because the implementation of the WfP reforms was made up as the policy makers went along (Ham, 1997). Ham *{ibid.)* argued much of the detail in the reforms was missing at its inception and policy had been made on the hoof He fiirther claimed that this allowed those at the periphery who were involved in purchasing and providing health services an unusual degree of freedom to influence and shape policy. This was a view endorsed by Klein (1989), who, at the time of the reforms, suggested that the balance between 'bureaucratic control at the centre and freedom at the periphery to respond to local demands may well move somewhat in favour of the latter' (Klein, 1989: 12).

Ham (1997) identified two important disadvantages with the emergent sfrategy. Firstly there has been a degree of ambiguity and inconsistency on the part of

[18] The National Health Service and Community Care Act (1990) allowed hospitals to opt for becoming independent agents or trusts for the purpose of setting prices for their services if they met certain conditions laid down by the DoH in order to become

politicians responsible for the reforms, as a result of making policy on the hoof In particular, Prime Ministers and Secretaries of State who have been associated with the reforms have each brought his or her agenda to the table. In the case of Margaret Thatcher, this was a belief in the value of the market as a means of improving performance. For Stephen Dorrell, towards the end of the Conservative administration in 1997, a major concem lay with controlling management costs. The other consequence of an emergent strategy was that difficulties arose during the course of implementation because insufficient thought had been given at the design stage to how the reforms would work in practice. Thus, what emerged was a degree of intervention from the centre via the NHSME beyond that which commentators predicted, which impacted adversely upon opportunities for greater middle manager influence (see section 3.5.3). This became particularly apparent in the empirical case of business planning represented in this thesis in chapter 5.

3.3.3 The NHS Management Executive (NHSME)

By the time of the WfP reforms in 1989, the DoH had installed 'a clear and effective chain of command' (DoH, 1989b: 13) upwards from Districts to Regions, the NHSME and then ultimately, the Secretary of State. As time went on, the tension between the philosophy of market relations and central control emerged as a key theme within the reforms as a whole. The 'clear chain of command' was further modified in 1993 as part of 'the continued drive towards decentralisation in the NHS, with responsibility and decision-making devolved as far as possible to local level' (Klein, 1995: 215), but the importance of the NHSME remained. It has become clear that a delicate balance has been stmck between management and competition and

independent frusts; eg. financial liability had to be demonstrated as a non-profit agency.

Government Ministers have demonstrated their willingness to intervene in the market when required to do so - for example, around waiting lists. An example of the increasing cenfral intervention, which has followed, is the introduction of performance indicators to judge comparative performance of different hospitals and health authorities in 1983.

There is evidence of continuity here since there is evidence of a tension between the centre and periphery in the WfP reforms that was also evident in the consensus management reforms (see section 3.3). This is also evident in the empirical case studies reported in the thesis where, in all but one of the case studies, intervention from the centre is a strong theme. For example, the management of the tension between the centre and periphery was apparent in the cases of human resource strategy at CCHT and Edwards Hospital.

Most notably in relation to the management of the human resource, the tension between centre and periphery is apparent in the determination of pay and conditions of employment. The creation of frusts in particular was regarded as cmcial in a drive towards local pay determination and the setting of terms and conditions of employment. Despite this, as one of the forces that acted against implementing local pay and conditions, there have been dictates from the cenfre. For example, in the 1996 pay award, a nationally agreed award of one and a half per cent was agreed at the cenfre and this was accompanied by 'advice' that frusts should top this up by one per cent locally. This is fiirther discussed in chapter 7 (see section 7.1.1).

3.4 The Middle Manager Experience in the NHS

Against this backdrop of the policy reforms described above, the experience of middle managers in the NHS has differed from that of middle managers generally. One of the main differences for middle managers in the NHS is that their numbers increased because of the implementation of general management and the intemal market during a period when, in the private sector at least, numbers of middle managers were declining. The de-layering of middle managers that was evident in the private sector from the mid-1970s onwards was not evident in the NHS until the mid-1990s when the Government advised that cost savings in management were necessary. Before discussing the increase in their numbers and elaboration of their role it is worth briefly commenting upon their experience prior to this since it provides a contrast to their role following reforms initiated in 1983 by the Griffiths Report (DHSS, 1983).

3.4.1 Consensus Management and the 'Diplomat' Manager (1974-1983)

On the basis of numerous research studies the picture of the pre-Griffiths NHS manager under the consensus management arrangements is a fairly coherent one. It shows the prime tasks of the manager to be problem solving, organisation maintenance, and the facilitation of processes. The middle manager in this period is best described as the 'diplomat' (Harrison, 1988: 51) or 'custodian' (Ackroyd eLal, 1989: 612-13). Harrison (1988) summarised the characteristics of the 'diplomat' manager in terms of four propositions:

'First, there was a disjunction between ostensible authority and real influence; put cmdely, NHS managers were not the most influential actors. Second, managerial

agendas were dominated by the need to react to problem situations rather than to pursue objectives. Third, managers were reluctant to question the value of existing pattems of activities and resource allocation, or to propose major changes in them. The corollary of this was that little interest was displayed in the evaluation of services. Fourth, the bulk of managerial attention was devoted to other groups of employees, rather than towards patients, relatives, or the community at large; managers were producer rather than consumer-oriented' (Harrison et al, 1992: 26).

At best consensus management decisions merely endorsed the status quo and ensured it ran smoothly. At worst difficult but necessary decisions were avoided. Under consensus management arrangements there was an absence of clear responsibility so that, 'there was nowhere for the buck to stop' (Maynard, 1983: 36). In addition, the role of diplomat managers adopted within the consensus management arrangements meant managers felt frustrated that they were not able to be proactive (Fairey et al, 1975; Schulz and Harrison, 1983)[19].

Such a role was deemed inadequate by the Griffiths Report (Harrison et al, 1989). The old consensus or 'diplomatic' management in the sense of a federation of separately managed occupations was to disappear (Harrison et al, 1992; Strong And Robinson 1988). The Griffiths Report's analysis was not new but it was expressed in blunt language. Klein (1995) quotes from Griffiths:

'The NHS was suffering from institutional stagnation; health authorities were being swamped with directives without being given direction; the NHS was an organisation in which it was exfremely difficult to achieve change; consensus decision-making led to long delays in the management process' (Klein, 1995: 147).

The post-1982 changes represented a very clear change to the philosophy of 'diplomatic' management. The most obvious example is the creation of general

[19] However, against this it should be noted that once doctors were disregarded, managers were the most influential amongst the remaining actors even prior to Griffiths (Harrison et al, 1992).

manager posts and the concomitant loss of professional influence generally, and specifically of the medical veto on the former management teams. This provided the potential for managerial influence over doctors and was complemented by personalised incentives and sanctions as appropriate motivators for general managers, so that this potential was realised (Harrison et al 1992). While arguing that the Griffiths Report (DHSS, 1983) represented a continuing preoccupation of central government with improving management in the NHS, Harrison et al *{ibid.)* emphasise that the general management ethos, which the Griffiths Report promoted, also represented significant change:

> General management can therefore be seen as, in principle, the antithesis of the 1974 system of consensus decision-making; just as this was a device for both maintaining professional autonomy of doctors and for maintaining the career aspirations of the other clinical professions so the advent of general management threatened both' (Harrison et al 1992: 49-50).

It is to the impact upon the middle manager role of the Griffiths Report (DHSS, 1983) that this chapter now tums.

3.4.2 The Griffiths Report and Middle Managers (1983-1989)

In criticising the previous consensus management arrangements the Griffiths Report (DHSS, 1983) highlighted the absence of clear managerial responsibility. Within Griffiths itself two quotes stand out as illusfrations of the management 'problem' of lack of clear responsibility:

'In short if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge' (Griffiths Report (DHSS, 1983), general observations, para. 5:12).

'To the outsider, it appears that when change of any kind is required, the NHS is so stmctured as to resemble a 'mobile': designed to move with any breath of air, but which in fact never changes its position and gives no clear indication of direction' (Griffiths Report (DHSS, 1983), general observations, para 8: 12)

From this diagnosis followed a clear prescription. There was a need for a general management stmcture from the top to the bottom of the NHS - that is, individuals, at all levels, responsible for making things happen. Implementation of the general management proposal, for Griffiths, was intended to identify 'people in charge' and to address the problem of implementation of policy. It aspired to change roles, 'ways of doing things', create a new cadre of 'leaders' who could energise decision-making, and even to produce 'a new culture' (Pettigrew et al 1992: 32). For Griffiths, general management implied a more strategic orientation and devolved responsibility for action.

In this way, the proposals in the Griffiths Report appeared to strengthen the hand of management in the NHS (Pollitt et al 1991, Stewart and Walsh, 1992). However, Griffiths recognised that change would not happen ovemight. He suggested that the reforms would take a decade to make an impact upon the UK NHS. As a result, at least until the 1995 reductions in middle manager numbers (see section 3.5.4), the NHS has seen an elaboration of general management in order to realise the intentions of the Griffiths Report (DHSS, 1983). There has been a spread of general managers through the organisation so that even ward sisters have been re-labeled 'team leaders' and manage porters, domestics, care team assistants and receptionists, as well as nursing staff (see section 3.5.3 and 3.5.4 for figures relating to increase in numbers).

However, again a tension between the centre and periphery was evident in what followed the Griffiths Report (DHSS, 1983). Post-Griffiths, reactive management remained the norm, though now the reactions were as often to some centrally-inspired initiative as to the medical and nursing pressures. In particular, local initiative for general managers was trapped within a national strait jacket as a result of financial stringency which cast a shadow over the Griffiths vision of a general manager led cultural revolution. In practice, in terms of content, 'without exception' (Harrison et al, 1989), general management agendas were dominated by financial considerations that reinforced top-down line management. Other commentators argued that not only were general managers being told what to do but also how to do it. For example, Best (1987) argued that the 1985 DHSS circular instmcting health authorities on the implementation of competitive tendering signalled a move to repossess general management. This tension between the cenfre and periphery was fiirther exacerbated by a pre-occupation with generic transfer of managerial ideas and practices driven by the centre, from private to public sector, of highly formalistic practices, such as business plarming (see chapter 5).

Thus, the model of proactive management promoted in the Griffiths Report (DHSS, 1983) remained a vision rather than a reality:

'There has been an absence of substantial change in the practice of NHS management [and] ... managers continued to be preoccupied with many of the concems which dominated their agendas, or those of their predecessors in the pre-Griffiths era' (Harrison et al, 1992: 114).

Despite this, Harrison et al (1992) also argue managers had laid claim to distinct sphere of management action and authority which they could not have done prior to the Griffiths Report (DHSS, 1983).

3.4.3 Working for Patients and Middle Managers (1989-1992)

WfP reforms showed continuity with Griffiths in its preoccupation with elaborating general management in the NHS since it intended considerable further strengthening of management and fiirther increased the status and power at least of senior managers (Harrison et al 1992). In terms of numbers the DoH reported that in the NHS the number of managers rose from 6,091 in 1989/90 to 20,478 in 1992/93, which was much larger increase than any other group of staff (cited in Ham, 1997). Some of this was due to reclassification of nursing staff into management grades but there was also real growth in the number of managers employed as a direct result of government policies.

In relation to the role of these managers, WfP clearly challenged the intemal political consensus, by threatening greater managerial control over doctors, and continued the move away from the implicit bargain of 1948 whereby financial power was concentrated at the centre and clinical power at the periphery. The move via WfP reforms from management by hierarchy to greater management by contract changed the role of general managers (Feriie et al, 1992). The centrally appointed cadre of general managers was the means to the introduction of such managerial levers as accountability reviews and value-for-money initiatives. As a result of WfP reforms, the general managers, of which middle managers were a significant part (Famham

and Horton, 1996; Pettigrew et al, 1992; Pollitt, 1990), 'must be informed, motivated and empowered, so that they can be proactive in making it [changes in management] happen' (NHSTD, 1992: 20).

The Griffiths Report (DHSS, 1983) and the reforms that followed strengthened the role of middle managers. Their role was enhanced because they were the instmments through which many of the changes were forced, empowered by the doctrine that 'management must manage' and that the market will allocate resources. This led to an increase in their numbers that differed from more general trends at the time in organisations to de-layer middle management (see section 1.3.1).

However, the response of central government described by Ham (1997) in the implementation of WfP reforms, which was outlined in section 3.4.2, is cmcial in the light of the research question since the increasing central prescription acted against any enhanced role for middle managers. On the one hand, general managers were appointed to fulfil leadership roles, with decision-making responsibility pushed down to where it really mattered and this was strengthened in the WfP reforms via decentralisation through marketisation. On the other, at the same time, the cenfre has constantly strived to increase its control over resources via a clear chain of command from the top to the bottom of the NHS.

Therefore, initial gains by middle managers may have been clawed back by contradictory forces at work where the centre has sought to intervene in issues which were politically contentious, such as managerial performance in the NHS or cost efficiency of healthcare delivery or waiting lists. This is an issue that this thesis seeks

to investigate empirically. One particulariy contentious issue about which successive governments have intervened has been the increase in managerial costs following the reforms. It is to this that we now tum to consider the impact of central government intervention upon any discretion at the periphery for middle managers.

3.4.4 Concern over Management Costs (1992 onwards)

More recently, since 1992, there have been attempts to marginalise and attack general managers in the NHS, which reflect more general organisational trends to restmcture and 'thin out' layers of management. This is not necessarily new, since both the 1974-79 Labour Government and the Conservative Government immediately following its election in 1979 had expressed similar concems about spiralling administrative costs in the NHS (Pettigrew et_al, 1992). However, following WfP reforms in particular there was increased concem over management costs.

Critics of the intemal market arrangements pointed to a rapid expansion in the number of managers of up to 10,000 between 1990 and 1993 (cited in Ranade, 1997: 106) as evidence of high transaction costs. Prompted by concem about increasing management costs, John Redwood, who was Secretary of State for Wales at the time, criticised the number of 'men in grey suits' in the NHS and asked for a reduction in their numbers (Ham, 1997). There followed a manpower review, which began in 1992, whose remit was to reduce management costs at all levels of the service. However, it appeared that management numbers were mainly reduced following the manpower review via abolition of regional health authorities, merging of district health authorities and family health services authorities, and reorganisation of the

NHSME, rather than through cuts at tmst level. Thus, in this review middle managers at tmst level appeared relatively unaffected.

However, attacks upon middle managers have continued (For example: Hancock, 1994; *Health Service Journal,* 1994a, 1994b). Even by 1994 however, managers still only accounted for three per cent of the total NHS workforce (cited in Ranade, 1997: 106), but they nevertheless proved to be an easy scapegoat for the growth of bureaucratic systems which politicians themselves introduced. This time the effect of attacks upon them has been more severe. In 1995, Stephen Dorrell, the last Health Secretary, prioritised the spiralling management costs in the NHS as of political concem, and issued guidance that 'M2' (a middle manager grade) costs were cut at tmst level by five per cent. Further to this an efficiency scmtiny was set up with the aim of reducing paperwork in the NHS. They reported in May 1996 and proposed that tight controls be introduced over management costs in health authorities and NHS tmsts with targets being set by Ministers for cutting expenditure and releasing resources for patient care. Alongside this, there was the continuing imposition of three per cent annual efficiency targets. Such targets, combined with a continual stream of interventions by the DoH[20] contradicted the rhetoric of devolution and decentralisation in official speeches and documentation.

This theme continues under the Labour Government elected in 1997. 'Planned reductions' of £44million in management costs and £18million from further management cost reductions would achieve another £62million. At the same time the

[20] Ranade (1997: 107) provides an example of DoH advice which she describes as bordering on 'silliness' whereby advice was proferred on the circumstances in which it was appropriate to offer coffee and sandwiches to those attending meetings. se attending meet: gs.

Executive will be looking for cost savings for 1998-99 and beyond (reported in *Health Service Journal,* 5th June 1997: 10).

In response to the targets set by the present Labour Government and the previous Conservative Government, tmsts are reclassifying jobs so that they are no longer included in the management cost category most heavily scmtinised, M2 cost (Industrial Relations Services, 1997)[21]. Perhaps that their role continues albeit under M3 cost or under nursing costs reflects the importance attached by tmst executive managers to the role which is carried out under the middle manager M2 heading. Nevertheless, despite such reclassifications, leaders of NHS Managers still expect savings on bureaucracy to come out of continuing managerial job losses (reported in *Health Service Journal,* 11th December, 1998: 4). It seems that a feature of the NHS is the contempt with which middle managers are held. Manager bashing has been an occupational hazard in the NHS for many years to the point where even the managers believe that the NHS has too many managers (Pettinger, 1998). It may be that any gains by middle managers in terms of their influence upon strategic change because of increased numbers or an enhanced role, which followed the Griffiths and intemal market reforms, have been taken back by such attacks upon middle manager numbers and their role.

However, there are signs within the practitioner community, that middle managers are being valued in the NHS, most notably in *Health Service Journal* (Wall, 1999), in which it was claimed that middle managers are 'trapped in an impossible job'. Wall *{ibid.)* argued that no organisation, including NHS organisations, can do without

middle managers. Further, Wall *{ibid.)* put the propensity of executive management to cut middle manager numbers as down partly to, 'innate prejudice that middle managers are people who haven't quite made the grade, so they are expendable. And partly, it is a mistaken idea that we do not after all need the bureaucracies which we ourselves have created' (Wall, *ibid:* 23). Wall describes both ways of thinking as, 'dangerously cmde' (Wall, *ibid:* 25). Later in the article, he advocates that we, 'give back middle managers their self-esteem by acknowledging that the organisation cannot work without them' (Wall, *ibid:* 25). This reflects more optimistic commentaries generally about the future role of middle managers, where it is claimed that they are cmcial to organisational transformation (see section 1.4). This thesis seeks to examine Wall's speculative proposition empirically. The empirical cases reported upon in chapters 5 to 8 will illustrate whether the role of middle managers in the NHS is one that is enhanced or not.

3.4.5 Middle Managers and the Medical Group

Having examined the imapct of successive reforms upon middle managers, it is necessary to consider how the reforms have impacted upon medical group power, given that the public sector strategic management literature, particulariy that of Mintzberg (1979, 1995), highhghts medical group influence on strategy (see section 2.2.3). Then fiirther to consider whether this has reconstituted realtions between the medical group and middle managers so that the latter enjoy an enhanced role in strategic change.

[21]This was apparent in one of the case study sites - Florence Hospital - where two of the three managers, participating in the management development programme, who were made redundant following Dorrell's 'advice' in Autumn 1995 to cut M2 costs,

Debate about the power of the medical group is multifaceted (Harrison and Nutley, 1996) and has a rich history of inquiry because it encompasses: the existence of the professions within management (Child et al, 1983); the professionalisation of management (Reed and Anthony, 1992) and the extent to which the professions are controlled by management or vice-versa (Raelin, 1995). As was sfressed in the previous chapter, formal management arrangements often have a limited influence on work processes in professional bureaucracies (Mintzberg, 1979), such as the NHS, because different professional groups can influence or resist managerial choices through a political, negotiated process (Bums, 1981; Strauss eLal, 1963). In particular the medical group enjoys significant power that may counteract or ignore bureaucratic authority (Clarke and Newman, 1997) although this is not simply a matter of bureaucracy and professions being polar opposites (Davies, 1983; Dopson, 1993).

The medical group, owing to their supreme professional status, have historically insisted on complete autonomy over health-related decisions in the hospitals and clinics in which they work. As a result 'the power of managers in the NHS to effect change is very limited' (Haywood and Alaszewski, 1980: 149), since the medical profession is able to define the purpose of the health services and control the actual delivery and general development of services (for example, see, Ham, 1981; Hunter, 1979). Therefore, while the focus of this thesis is upon middle managers the influence of middle managers upon strategic change cannot be discussed without reference to medical group power, since in hospitals for example, they are dominant. A cmcial question is, if middle managers enjoy an enhanced role, to what extent does this extend beyond the administrative domain to that of the professional domain, particularly that of the medical group.

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were then subsequently redeployed under a non-management cost heading.

As a starting point to a discussion of the relationship between middle managers and the medical group and the constraint that the latter group may impose upon any opportunity for enhanced influence for middle managers, it is useful firstly to discuss the nature of the medical group as a profession and the historical development of this.

3.4.5 (a) *The Medical Group as a Profession*

3.4.5 (a) (i) *Characteristics of Medical Profession*

Feriie et al (1996) set out commonly agreed characteristics of a profession. They describe these as follows. There is a body of expert knowledge over which the profession exercises a degree of control and, in the purest form, a monopoly of practice. The profession sets standards of training and controls entry to the group. Once professional membership has been achieved, members of the profession relate to each other on a collegial basis. Finally, within a profession, individuals - as holders of specialist expertise - expect to exercise a degree of autonomy over their work and their work processes. In the NHS medical group power largely flows from their clinical autonomy through which they can influence pattems and priorities of health care:

' ... the type of organisation found in the NHS, and the distribution of power and authority within it, is deeply affected by doctors' special relationship to their patients, which is at the core of clinical autonomy. We have argued elsewhere (Harrison et al, 1989: 40) that 'claims to clinical freedom on the part of doctors can be seen as resistance against control over health care providers'... there is a general perception that the concem of managers with budgets, priorities and the health of whole populations across localities is different from that of doctors, which centres on individual patients, meeting individual need and on not allowing resource issues

explicitly to intrude into or dominate clinical decisions' (Boyd, 1979, cited in Harrison et al 1992).

In considering the management-medical group interface the concept of clinical autonomy will be retumed to. Firstly, however, it is usefiil to briefly describe the process by which the medical group gained its current dominant position.

3.4.5 (a)(ii) *Development of the Medical Profession*

LUewellyn (1997) gives a concise description of the initial development of the medical profession. In 1858 the Medical Act was passed. This act created the General Medical Council, a body with two main duties, to ensure that unfit practitioners do not get on to the medical register and to expel unworthy members from the profession (Carr-Saunders and Wilson, 1933). The Council, imbued with the prestige and authority of the state, formalised the principles of, first, proper professional education (tested by examination and awarded by licence), second, professional self-discipline (through registration and striking off) and third, statutory recognition of the rights of the qualified practitioner (with sanctions against the unregistered); These principles instituted that most attribute of professionalism ... 'the closed shop with an Act of Parliament to lock the door' (Reader, 1966: 68).

The power of the medical profession has been fiarther enhanced by the belief that through human action in the form of social engineering and using scientific knowledge, health can be produced and illness eliminated (Kelly and Glover, 1996.). As a result attention has been directed at hospitals as the centres for technological

progress in health care and, hence, as the determinants of the future health of the nation (Llewellyn, 1997).

That the medical group had a dominant position, as a result of the Act of Parliament and the behef that the scourge of illness was within reach (Kelly and Glover, 1996) through progress in health care technology, was evident during the inception of the NHS. A number of commentators have highlighted the bargaining and negotiation that produced the structure of the NHS in 1948 (Dopson, 1997; Eckstein, 1958, 1960; Klein, 1995; Webster, 1988) and gave the medical group a privileged position in which a number of concessions were granted to them (Dopson, 1997). Klein (1995) summarises the extent to which the medical group was granted influence in the NHS:

'In the case of hospital services, the NHS was designed to accommodate certain specific interests within the medical profession ... most important perhaps for the fiiture, the medical profession obtained a monopoly of legitimacy among the health service providers: a unique position, reflected in the participation of doctors in the mnning of the NHS' (Klein, 1995: 25).

For example, Harrison et al (1992) describes how the close relationship at national level between the government and the medical profession gives doctors direct access (without going through managers in health authorities) to government, with the opportunity both to shape official thinking about policy in general and to veto unwelcome developments. They describe how the British and Medical Association and the Royal Colleges (of Physicians and Surgeons) is in constant and close contact with ministers and officials (Castle, 1980; Crossman, 1977), being consulted on matters going far beyond the narrow terms of employment of their members (Harrison, 1981; Harrison et al 1990).

However, while doctors have taken a lead in securing a position of national influence both in the formation of the NHS and subsequent re-organisations in 1974 and 1982 (Eckstein, 1958; Forsyth, 1966; Haywood and Alaszewski, 1980), on the local stage there appears to be a great deal of reluctance on the part of doctors to get involved in local management of health services (Dopson, 1993). At a local level doctors have been engaged in the management of their hospitals in different forms since the inception of the NHS but developing their involvement has been problematic (Buchanan et al, 1998; Dopson, 1993). Both Buchanan et al (1998) and Harrison et al (1992) draw attention to the power of the medical profession to influence management but note that, 'there is little sense of doctors wishing to engage in management with a positive sense of purpose or ambition' (Buchanan et al, 1998: 4). At the local level, formal organisational arrangements have been so designed as to leave doctors free from day to day management, and to leave members of other clinical professions managed only by other members of their own profession. Important in these arrangements is the notion of clinical freedom whereby a fully qualified doctor cannot be directed in his or her clinical work (Harrison et al, 1992). Therefore, middle managers are likely to experience difficulties in influencing medical group activity.

However, there have been attempts to challenge medical group dominance in the NHS since its inception, the 1974 reorganisation of the NHS representing the first significant attempt to challenge clinical power (Dopson, 1996). This was followed by the Griffiths Report (DHSS, 1983) and *Working for Patients* (1989). In particular the development of the clinical directorate model combined with resource pressures facing the NHS may weaken the traditionally negative attitude of doctors towards

management (Riordan and Simpson, 1995; Simpson, 1995). ft is to these challenges, their implications for the manager:medical group interface and the response of the medical group we now tum.

3.4.5 (b) *Challenges to Medical Group and Responses*

3.4.5 (b)(i) *1974 Consensus Management Arrangements*

Prior to 1974, doctors had a great influence on the pattems and priorities of health care without needing to take up formally-defined administrative roles. Studies reveal that decisions affecting local health care delivery evolved in bargaining situations where the distribution of power is weighted towards the medical profession (Dopson, 1996). Dopson *{ibid.)* quotes Ham (1981) to illustrate the power of the medical profession prior to 1974:

'The history of hospital plarming between 1948 and 1974 can be seen as the history of corporate rationalizers represented by Regional Board planners, trying to challenge the established interests of the medical profession with the community hardly in earshot (Ham, 1981:75).

The 1974 reorganisation (see section 3.3) did not appear to make significant inroads into medical group power. Harrison et al (1992) cite a number of studies (for example, Elcock and Haywood, 1980; Harrison, 1981; Haywood and Alaszewski, 1980) to show how, despite the 1974 reforms, the strategic shape of the NHS was dominated by the medical profession prior to the Griffiths reforms (DHSS, 1983) and change was incremental/marginal and management were merely diplomats or maintainers (Harrison et al, 1989c). Dopson's study also questions the assumption of the 1974

restmcturing that 'management is a rational process where policy is made by the centre, transmitted to the periphery and implemented there' (Dopson, 1993: 2). Instead, 'health care systems can, and do, circumvent national policies' and fiirther 'although policy processes at a local level are incremental and plural, the distribution of power is weighted towards the medical profession"(Dopson, 1993: 2).

Harrison et al (1992) also suggested that any enhancement of the NHS manager from the diplomat role would represent a challenge to medical power, and its success would be cmcially dependent upon the effectiveness of such a challenge. This was likely to be difficult given the power of doctors, left to themselves, to deal with problems, such as the ability to ration health care, that managers (and politicians) found difficult (Harrison et al, 1992; Hinings et al, 1971); that is, there was managerial dependence upon professionals. The Griffiths Report (DHSS, 1983) offered some opportunity for managers to enhance their power but any diminution of medical group power was likely to be contested. It is to this and the response of the medical group we now tum.

3.4.5 (b)(ii) *Griffiths Report*

The Griffiths Report (DHSS, 1983) was aimed at curtailing the power of the medical profession (Dopson, 1996) as a resuh of a need mainly to curtail pubhc expenditure (Harrison, 1988). It reflected a more critical attitude towards the power of doctors to shape pattems of care and their dominant position in the doctor:patient relationship (Dopson, 1993).

Dopson (1993; 1996) views the impact of Griffiths with respect to doctors as being one which attempted a change from one where health services were administered to one where health services were managed with the medical group playing a key role. However, she notes this as slow to emerge with, 'general managers [being] ... singularly unsuccessful in involving clinicians in managing their services, in changing the pattem of health services and enhancing consumer power.' (Dopson, 1996: 176). The view of consultants in Dopson's study was that the introduction of general management had not made a significant difference to the doctor's role (Dopson, *ibid.).*

At the time of writing, post-Griffiths implementation but at a time when the implications of the intemal market were emerging, Harrison et al (1992) also suggested that general management had not yet transformed the relationship between doctors and managers. They claim that there were some exceptions but these were rare and only specific instances in particular localities rather than a general trend. Generally, so far as doctors were concemed regarding the impact of Griffiths, the diplomat role for managers had not changed much (Harrison et al *ibid.).* As Harrison notes:

'The prime determinant of the pattem of services is still just as before Griffiths, what doctors choose to do' (Harrison, 1988: 123).

3.4.5 (b)(iii) *Working for Patients (*WfP*)*

The WfP reforms (DoH, 1989a) appeared to challenge medical group power to a greater extent than the 1974 consensus management arrangements or the Griffiths

Report (DHSS, 1983) but adaptive responses from the medical group have diluted its potential impact.

Harrison et al (1992), for example, see the WfP reforms as putting 'several additional levers of power and persuasion into manager's hands (Harrison eLal, 1992: 146). In a quasi-market situation, provider managers need a means of controlling their organisation's output so as to allow the terms of the contracts into which they have entered to be met. This has led to a range of intemal line-managerial arrangements, which have buih upon the general management changes introduced by the Griffiths report. Harrison (1999) describes how resultant forces from WfP come together to allow managers to challenge clinical autonomy. For example newly formed posts of Medical Directors and Clinical Directors were taken up by the medical group and medics were persuaded to think in more managerial terms by budgetary constraints and by 'mbbing shoulders' with managers (Harrison and Pollitt, 1994). Also, as illustrated in the empirical chapters, access to audit data gave managers some influence over the medical group regarding resource utilisation. Tmst managers also had greater control over medical appointments and terms and conditions of employment. In addition, hospital consultants were required to have job plans, which specify how their working week was to be spent.

Despite these forces, Harrison et al (1992: 146) 'predict no spectacular collapse of the medical citadel'. Whilst managers developed a distinct sphere of management action and authority that was not apparent in the past, Harrison eLal (1992) suggested that the medical group were capable of adapting central initiatives, such as 'managed competition', for their own ends. For example, in taking up the posts of Medical

Director and Clinical Director, it has also been noted that 'the medical motives for accepting managerial responsibility may be primarily defensive' (Buchanan et al, 1998: 6). Crompton (1990) also noted the ability of the medical profession to resist 'quasi-market' forces. This was a resuh of, 'most doctors and most managers continu[ing] to inhabit a shared culture of medical autonomy' (Harrison et al, 1989b: 44). There were also some additional factors that limited any managerial ascendancy (Harrison, 1999). One was the impending shortage of UK trained doctors for many specialties. Another is the continuing centrality of doctors in the hospital workflow, which gives them a good deal of collective influence (Hinings *etal*, 1971).

Feriie et al (1996) added further to the view that the medical group had retained power following WfP, by adopting new roles such as clinical directors, adapting to them, and becoming involved in the management process. As a result, they argued that managers have not necessarily gained power at the expense of the medical group. However, they noted that the boundaries and divisions between specialist-professional managers, such as those in the medical group, and general managers were blurring. Processes of team-working within clinical directorates[22] saw clinical directors and medical directors working alongside general managers and other professional managers such as nurse managers and paramedic managers, with medical managers playing a specialist role rather than a general management role. As McKee et al (1999) point out, following a large-scale empirically-based study, while few clinical directors attempted to fiilfil a middle management role they retained power through clinical autonomy and their ability to influence strategic change through this.

[22] This was also noted by McKee et al (1999).

These adaptive responses from the medical group in response to the policy change towards general management, argue Feriie et al (1996), challenge the simplistic view that managers have gained power and roles from the medical group. Whittington et al (1994) further claimed that the shift to a market-driven regime actually entailed some risk to control as the medical group manipulated market opportunities and rhetoric for themselves and tried to sell their services to GP ftmdholders (the emergence of part-time marketers is elaborated upon in chapter 6). Finally, Ackroyd (1996) highlighted the importance of the medical group in the realisation of policy reform in the NHS:

'Many managers recognize that they will never make headway unless they achieve the tacit support of a high proportion of the senior doctors, because it is through the actions of senior doctors to gain their consent, including the idea that they can be recmited to management positions' (Ackroyd, 1996: 613).

However WfP reforms may offer some increased scope for managerial influence over the medical group and hence the realisation of strategic change in healthcare organisations. In a study of market-driven change processes, Whittington et al (1994) highlighted teamworking aspects of the new arrangements, claiming that dependence on markets was eroding traditional hierarchies, as a result of which there was more collaborative interaction between nursing managers and clinical directors in the NHS. Dent (1993: 265) is also of the opinion that the WfP reforms involved a fundamental change in the relationship between doctors and the state that meant, 'the medical profession accepting the principles *of responsible autonomy* within an overall system of managerial control' (original emphasis). Finally, Glover and Leopold (1996) in their concluding chapter to a collection of readings on the subject of the limits of management in the NHS, argue that while doctors are capable of resisting managerial change effectively, the notion of gains for doctors being exchanged for losses is also

significant. They suggest that there seems to be some sort of price to be paid by a professional group when it enhances its position in a time of managerial change, for example, that they fill senior management jobs (Ashbumer, 1996) or that they develop co-operative working relationships with general managers (Fitzgerald, 1996). So while it is simplistic to suggest that managers have gained power from the medical group, there does appear to be increased scope for managers to influence the medical group because of the policy reforms.

In summary, it seems clear that of the multitude of professions in the NHS, that the established medical profession has lost least in terms of occupational control and organisational power as a result of the general management and intemal market reforms (Harrison and Nutley, 1996). One reason may be that the trend to decentralise management responsibilities down the hierarchy is a key aspect of the new managerialism in the public sector (Exworthy and Halford, 1999). 'Rather than attempt to strengthen "management" in order to control "professionals" the strategy shifts towards creating managers out of professionals' (Hoggett, 1991: 254). As a result the medical group have incorporated managerialism through their adoption of managerial roles such as clinical directors and medical directors. Another is that explicit managerial rationing of health care would undermine confidence in the NHS (Harrison, 1999). The public regards doctors, rather than either politicians or NHS managers, as the legitimate decision-makers about the availability of freatments on the NHS (Bowling, 1996: Heginbotham, 1993). However, it has also been stressed that doctors can't ignore how money is spent or controlled or retreat into 'islands of managerial immunity' (McKee et al, 1999; 111) and that there is scope for managers to influence clinicians via negotiation and building networks (McKee et al, *ibid.).*

3.5 Summary

In summary, the tensions between sfrengthening of the general management group and processes of de-layering in the NHS have similarities to the more widespread organisational trend to de-layer middle management, whilst advocating that those remaining should be come more entrepreneurial and innovative. The introduction of general management and the intemal market appeared to strengthen the role of middle managers. 'Hard-nosed' performance measures - the 'efficiency drive' of NPMl (Feriie et al, 1996) - were instituted alongside a less visible emphasis upon culture change - the 'search for excellence' of NPM3 (Feriie et al, *ibid.).* As part of this, the balance between bureaucratic control at the centre and discretion for middle managers to respond to local problems was expected to move in favour of the latter as responsibility was pushed down the line. However, from 1992 onwards, there was evidence of downsizing and delayering in evidence - some aspects of 'downsizing and decentralisation' of NPM2 (Feriie et al 1996). Financial consfraints in the NHS led to attacks upon their numbers and their role from central government.

However, the experience of middle managers in the NHS differs slightly, from that of middle managers generally, in three ways. Firstly, there appears to be a time lag between their experience more generally and their experience in the NHS. The de-layering of middle managers in the private sector can be regarded as a feature of the 1980s. This was a decade when middle manager numbers in the NHS were growing. In the NHS the drive for de-layering did not begin in eamest until Stephen Dorrell's guidance that M2 numbers be cut in 1995.

Secondly, there is a re-thinking of the middle manager role in the management literature generally, more recently, by some academic commentators, who argue that the middle manager role should be enhanced, as previously discussed (see section 1.4 and 2.3). Further, in the management literature generally, it is recognised that de-layering of middle managers and an enhancement of their role can take place simuhaneously (see section 1.4). Only Wall (1999) appears to recognise the importance of the role of middle managers in the NHS (see section 3.5.4). In the NHS, however, there is an 'either-or' conception of the importance of middle managers, where their numbers increase and they are encouraged to be proactive in driving change, or their numbers decrease and their roles are reduced. Such a conception needs to be questioned. It may be that, in the NHS more optimistic readings of the role of the middle managers, whereby their role can be enhanced whilst de-layering takes place, may be valid. As outlined in the summary to chapter 1, middle managers have a pivotal and contradictory role in the corporate restmcturing process, whereby they are simultaneously objects and subjects of corporate decline and reconstmction (Newell and Dopson, 1995; Daudi et al, 1997; Smith, 1997).

Thirdly, besides a greater degree of central government intervention that increasingly prescribes the activities of middle managers, a significant additional constraint upon the realisation of an enhanced middle manager role in the NHS is the presence of a powerful medical group.

The thesis now turns to an empirical investigation of the role of middle managers in the NHS, considering whether middle managers can enjoy an enhanced role. This analysis will draw upon the sfrategic change hterature set out in the chapter 2 of the

thesis. However, before the empirical case studies are discussed, in the next chapter, the methodology by which the data is produced is described and rationalised.

Chapter 4

Methodology

4.1 Introduction

Firstly, this chapter outlines the methodological approach adopted in this research study and the reasons for its adoption. It then describes and rationalises the research techniques utilised. This includes a commentary upon the pre-fieldwork stage of the research study, including the selection of case studies as examples of strategic change and selection of middle managers to interview, as well as the fieldwork techniques of the interview, observation and document collection. Finally, prior to a summary, it offers some reflection upon the methodology. It then describes and rationalises data analysis.

Figures 4.1a and 4.1b provide a sununary of the methodology (on pages 143 and 144). Figure 4.1a outlines the general process and timing of data gathering and analysis in the five case studies carried out across three organisations - the Florence Hospital, City Community Health Tmst (CCHT) and Edwards Hospital[23]. Figure 4.1b outlines the process and timing of data gathering and analysis in the cases within Florence Hospital.

[23] All trusts considered in this thesis have been given pseudonyms so that anonymity for respondents in the research process is ensured. This was also a condition of the granting of access to the researcher.

Figure 4.1a: Methodology

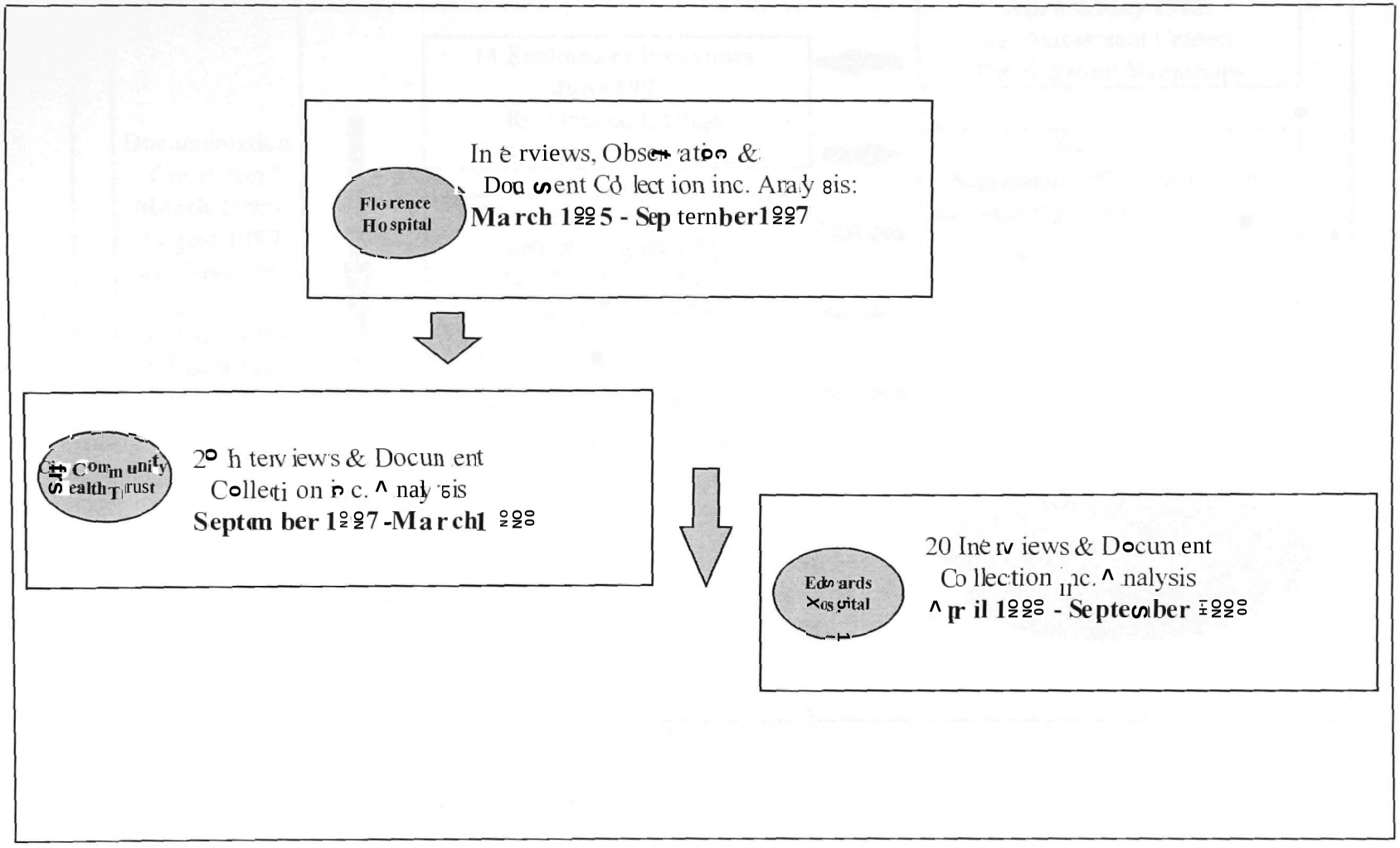
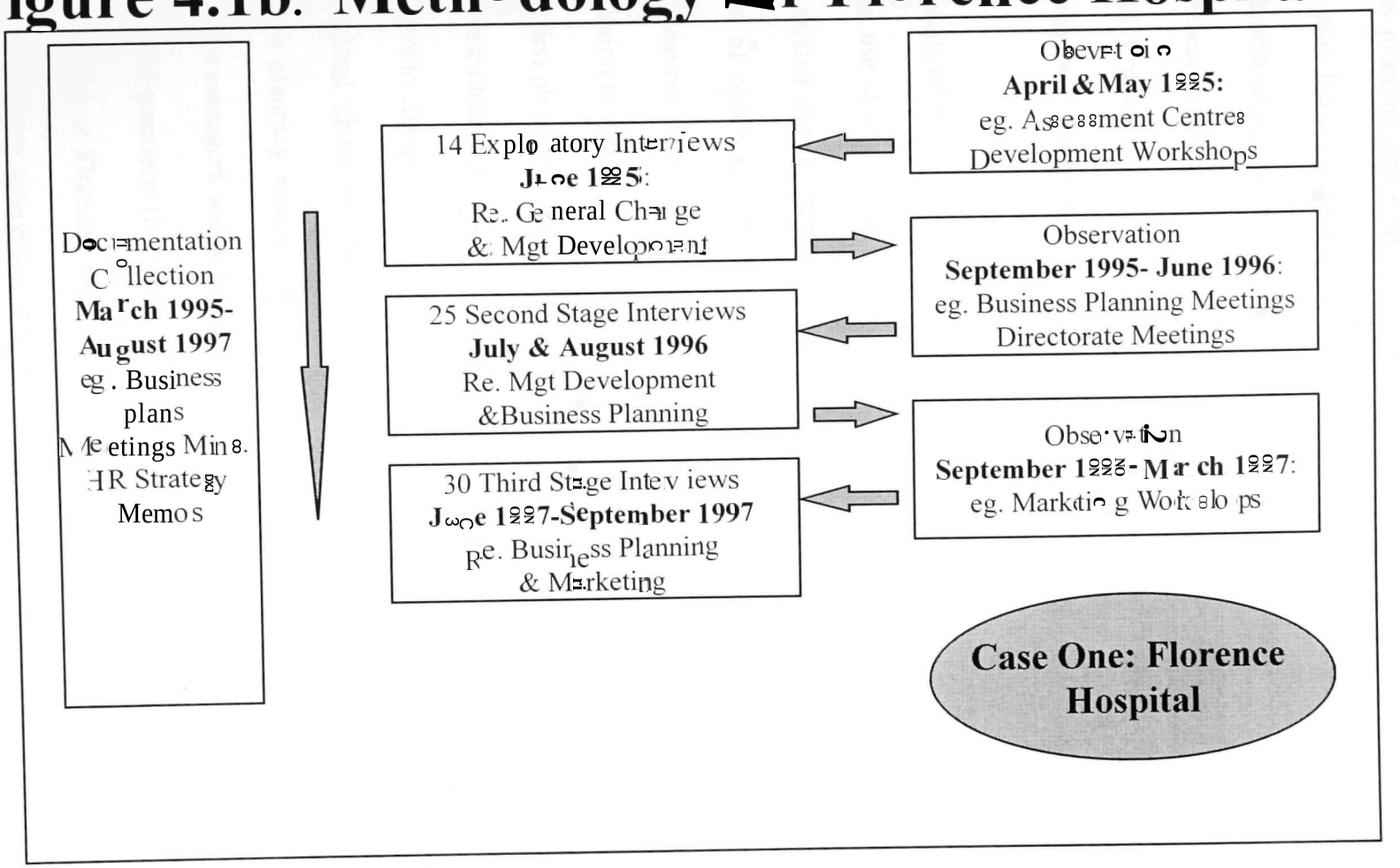


Figure 4.1b: Methodology Dr Florence Hospital



Successive case studies took place across the organisations - management education, business planning and marketing in Florence Hospital, human resource sfrategy in CCHT and human resource sfrategy in Edwards Hospital. One of the cases - management education at Florence Hospital - is not fiilly represented in this thesis but nevertheless informs analysis. The case of management education at Florence Hospital is outlined in the introduction to chapter 5 and an elaborated version appears *in Management Learning* (Currie, 1999).

The details of the research are elaborated upon in later sections. However, a summary may be useful as a guide for the reader. In summary 69 semi-stmctured interviews were carried out at Florence Hospital in 3 phases, these being interspersed with periods of observation that focused firstly upon management education, secondly upon business planning and thirdly upon marketing, but also included more general observation of directorate meetings or workshadowing middle managers for example. In the first phase of interviewing at Florence Hospital 14 interviews were carried out with the middle management group. These elicited data about the response of middle managers to change including the management education programme being observed. The second phase of interviews at Florence Hospital focused mainly upon the business plarming process. 25 interviews were undertaken with middle managers, executive managers and a limited number of the medical group, who had taken up managerial positions (2 Clinical Directors, 1 Medical Director). The final phase of interviewing at Florence followed observation of marketing workshops and other activities. These interviews discussed the researcher's emerging analysis of the influence of middle managers in the cases of management education and business planning but a large part was taken up with discussion of the role of middle managers

in the realisation of marketing sfrategy. The interview schedules are documented in appendices A to C for the cases investigated in Florence Hospital. Relevant documentation was also analysed at Florence Hospital - for example, business plans and minutes of board and directorate meetings. As described in the introduction the approach was inductive and moved from general questions about responses to change in the first phase of interviewing at Florence to discussion about the influence of middle managers upon strategic change in the specific case studies.

Emerging analysis was taken forward to CCHT in which the realisation of HR strategy was investigated with a focus upon the influence of middle managers. In this case 20 semi-stmctured interviews took place with middle managers and executive managers, the latter group including a Medical Director but one who was drawn from the dental profession, since doctors were not directly employed by the tmst. The interview schedule for HR strategy at CCHT is documented in appendix D. Again in this case, relevant documentation, such as the HR strategy, was gathered, but there was no workshadowing or observation of meetings, for example.

In the final successive case, that of HR strategy at Edwards, 20 interviews were carried out. Interviews were carried out with 12 middle managers, 6 advisors or managers in the Personnel fianction and 2 executive directors. Of these interviewees, 3 were from the medical group (2 Clinical Directors and the acting Chief Executive, who was also Medical Director). The interview schedule is documented in appendix E for the case of HR sfrategy at Edwards Hospital. Also, in this case, relevant documentation was gathered such as the HR strategy.

In the opening section to this chapter, firstly the characteristics of qualitative research are considered. Secondly, the principles of the case study method and the reasons for the use of case studies are discussed.

4.1.1 Qualitative Approach

The frame of reference for the methodology adopted in this thesis is the interpretive paradigm (Burrell and Morgan 1979) and a qualitative approach is taken, with features of case study research (Eisenhardt, 1989; Yin 1994) and ethnographic principles (Hammersley and Atkinson 1995). The methodology reflects the frizzy boundaries between what constitutes qualitative research, and what a case study or ethnographic approach specifically constitutes (Silverman 1993). The methodology also illustrates that qualitative methodology is a craft-like process and that strict adherence to principles laid out for case study research (Yin, 1994) or ethnography (Hammersley and Atkinson, 1995), may be overly restrictive. As Bryman and Burgess (1993) suggest, qualitative methodology covers a diverse range of approaches. For example, Hammersley and Atkinson state in their interpretation of ethnographic principles:

> 'The boundaries around ethnography are necessarily unclear. In particular, we would not want to make any hard and fast distinction between ethnography and other sorts of qualitative enquiry' (Hammersley and Atkinson, 1995: 2).

Even in the case of Yin (1994) who claims that the case study should not be confused with 'qualitative research' or ethnographies, there is a later admission that:

'The basic approach, however, is to consider all the strategies in a pluralistic fashion - as part of a repertoire for doing social science research from which the investigator may draw according to a given situation' (Yin, 1994: 15).

In the case of the ethnographic principles emphasised in this research attempts are made to make clear the role of the researcher as an active participant in the research process. The methodology chapter provides the vehicle for doing this and allowing the reader to understand how the data represented in the case studies (chapters 5 to 8) was produced. In doing this, the researcher hopes to allow some replicability of the methodology. However this may be limited due to the nature of qualitative methodology as a craft rather than a set of prescriptions.,

It is worth considering the methodology of the research study reported here against the guidelines set out for qualitative research by Taylor and Bogdan (1984: 5-8)[24]. On the one hand, Taylor and Bogdan *{ibid.),* while emphasising participant observation as the mainstay of qualitative research, nevertheless provide a perspective, which is reflected in this study. They define qualitative methodology as being how to collect descriptive data examining people's own words and behaviour, or how to study social life phenomenologically - that is reality as socially constmcted (Berger and Luckmann 1967). The researcher in this study assumes reality to be socially constmcted. In addition, similariy to Taylor and Bogdan (1984) qualitative research was conceived as craft-like because, while it can draw upon principles outlined in methodology texts, it cannot be refined and standardised to a set of generic prescriptions.

[24]The researcher uses the label 'guidelines' rather than 'principles' since qualitative methodology may be seen as a craft rather than a methodology which can be prescriptively laid down (Bryman and Burgess, 1993; Hammersley and Atkinson, 1995).

On the other hand, the researcher finds himself in conflict with some of the suggestions of Taylor and Bogdan (1984). In particular, they suggest that the qualitative researcher suspends, or sets aside, their own beliefs, perspectives and pre-dispositions. The researcher in this study feh this was unrealistic, at least in this thesis, since he brought a level of pre-understanding into the study from his previous 'life' as a Management Development Advisor in a district health authority. In addition, conflicting with guidelines set out by Taylor and Bogdan *{ibid.),* the researcher identified general research questions following an initial literature review even in the exploratory stages of the research to guide data gathering. Finally, in this research study, a decision to focus on a particular group of stakeholders in the NHS - middle managers - was made earlier than Taylor and Bogdan *{ibid.)* imply in their comment that all settings and people are worthy of study. The researcher (from previous experience and literature review) in this study believed that middle managers were likely to resist strategic change driven in a top-down manner and focused upon this issue. This initial theoretical proposition was elaborated subsequently to also include consideration of the influence of middle managers upon strategic change under conditions in which it was emergent.

4.1.2 The Case Study Method

The need for successive case studies to deepen sociological understanding is widely acknowledged (Compton and Jones 1988). As Hartley (1994) suggests, the case study is appropriate where there is an emphasis on understanding processes alongside their organisational context. The reasons for using case studies are elaborated by Eisenhardt (1989) and Yin (1994). In general case studies are the preferred sfrategy

when 'how' and 'why' questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real life context. These latter conditions apply in the empirical cases reported upon in chapters 5 to 8 and the research question is one that concems itself with 'how' middle managers influence strategic change. The case study's unique strength is its ability to deal with a full variety of evidence - documents, artifacts, interviews and observation.

In considering the design and methods laid out by Eisenhardt (1989) and Yin (1994) in case study research there are a number of principles taken on board which were seen to enhance the rigour of this research study. Firstly, a cmcial question for the researcher concemed the study proposition and unit of analysis - that is, a concem with what the case was and what should be studied. The case was generally about organisational change, the unit of analysis was the role of middle managers in this, and there were a number of cases within this of organisational interventions. Middle managers were seen as managers whose emphasis in their formal role lay with tactical or operational decision-making and who were excluded, at least formally, from strategic decision-making (see chapter 1 for fuller definition and section 4.3.1(b)(i) for who this includes in each case study). Their role lay beyond the people management, which was emphasised in first line managers' roles.

Secondly, theory development was also part of the design phase of the case study. The use of theory, in doing the case studies, not only proved an immense aid in defining the appropriate research design and data collection but also became the main vehicle for generalising the results of the case studies. In case study work an analysis

developed regarding process, which is then applicable on a wider basis. In this way case studies rely upon analytical or theoretical generalisation rather than statistical generahsation about the whole population (Yin, 1994).

In CCHT and Edwards Hospital emergent concepts from the first three cases, carried out in the Florence Hospital, were elaborated upon - for example, conditions under which middle managers could enjoy an enhanced role in the realisation of strategic change. Eisenhardt (1989) adopted such a strategy where each case built upon the findings from an eariier case or cases. Further, Pettigrew et al (1992) justified their use of a number of case studies as forcing compare and contrast analysis and building up a larger number of case studies which could be used as a basis for theory building.

4.2 Fieldwork Issues

Having outlined the methodological approach taken in the research, the process of entering and leaving the field and the choice of cases within this are now described.

4.2.1 Entering and Leaving the Field

In the first stage of the research, the researcher spent over two years collecting data (March 1995 - September 1997) in the Florence Hospital including attendance on a fiill-time basis from the start of Febmary 1996 to the end of September 1996. Data-gathering took place here in three successive case studies, as described later. Observation represented a significant element of data collection in all three cases alongside interviews and document collection.

Data was gathered in a fiirther two case studies following the Florence Hospital case study. Firstly, data was gathered and analysed in CCHT (CCHT) between September 1997 and March 1998 around the realisation of human resource strategy. Secondly, following this data was gathered and analysed around human resource strategy at Edwards Hospital from April until September 1998.

4.2.1 (a) ***Pre-Fieldwork***

There are number of issues raised in considering the pre-fieldwork stage of the research, which the reader should note. Firstly, some exploratory research is necessary, around any proposed case, to establish the usefulness of the case study for illuminating the research question. Secondly, often access has to be negotiated through an individual in the organisation who has some influence to 'open doors' for the researcher. Thirdly, this individual, who provides access, may want some contribution from the researcher towards solving a problem within the organisation. Fourthly, as discussed in section 4.1.3, the process of successive case studies meant that the issues with which the researcher was concemed became more narrowly defined following each case. Therefore, the first issue above, that the case study usefully illuminates the research question, becomes more important. Each of these will be discussed in this section 4.2.1. Given that the four issues are related, necessarily they are considered together.

Entry to the field is not something that should be taken for granted and unworthy of comment. Eisenhardt (1989) gives prominence to this. In this light it is worth

descnbing the process of gaining access to the case study organisations. The background to entering Florence Hospital was as follows. The researcher was aware through personal contacts that the School of Management and School of Health in a new university, had won a contract to deliver a management development programme to middle managers at Florence Hospital. The management development programme, which they were to deliver, appeared to provide an opportunity to illuminate the research question, which at this stage, while focusing upon middle managers, was a more general question about cultural change in healthcare trusts[25]. A process of 'casing the joint' (Schatzman and Strauss, 1973), which involves the researcher ascertaining the suitability of the case study organisation for empirically illustrating the research question, was carried out before formally approaching the Florence Hospital with a concrete proposal. To 'case the joint' the researcher informally interviewed the Dean of the School of Health and some of her staff who had in-depth knowledge of Florence Hospital, as well as the lead facilitator for the programme from the School of Management. The researcher attached himself to the 'coat tails' of the programme delivery team leaders in initially approaching the human resource department in the hospital. In this initial approach the researcher presented himself to the gatekeepers (those stakeholders who were likely to confrol access into the organisation for the researcher in the Human Resource Department - Director of Human Resources and the Organisation Development Manager) as potentially being able to provide objective feedback on the impact of the programme.[26]

However, the contribution of the researcher towards organisational problem-solving was limited. Apart from influencing the thinking of the Organisation Development

[25]As noted in chapter 2 (:62, footnote), given the large amount of attention that has been paid to organisational culture in the management literature, the thesis is not concemed with the issue of management of culture.

Manager the researcher made little impact on organisational policy and practice. Firstly, executive management in Florence Hospital viewed the interests of the researcher as being of academic concem only.[27] Secondly, executive management in Florence Hospital regarded the approach adopted by the researcher as unorthodox in an environment where quantitative performance indicators were the norm. The impact of such a narrow view of performance is particulariy evident in the cases of business planning at Florence Hospital (chapter 5). On a number of occasions the research agenda and approach was referred to as, *'whatever it is that you do',* despite frequent explanations and justifications of the approach by the researcher.

Perhaps this was just as well. One of the ironies of observing organisations is that once researchers have obtained access from gatekeepers, they typically must disassociate themselves from gatekeepers (Van Maanen et al 1982). In this research study, in order to gain the confidence of middle managers, many of whom had a clinical background, the researcher had to distance himself from the Central Directorate in which the Human Resource Department was placed at Florence Hospital. He emphasised his role as an academic to do this, hoping that the middle managers would view the researcher as a fellow professional who was working and being subjected to changes in an environment not dissimilar to that of a health care setting.

The subsequent case studies, CCHT and Edwards Hospital, were selected on the basis that they would elaborate upon the theoretical framework developed from Florence

[26]The status of the researcher as a mechanism for feedback was used in documentation produced by the Human Resource Department for Investors in People (IIP) accreditation purposes.
[27]This was viewed as a source of data itself The researcher asked himself whether this reflected a lack of debate in the organisation about the legitimacy of managerialism.

Hospital[28]. Following the longitudinal study at Florence Hospital, themes were identified that were to be focused upon more narrowly. Since the cases in Florence Hospital offered glimpses of an enhanced middle manager role, particularly in the case of marketing, the researcher was interested in carrying out research in a tmst that might more fully illustrate this enhanced role and the conditions necessary for it. CCHT appeared to offer this since it had been identified as following a progressive human resource strategy - particularly in relation to local pay, where over 80 per cent of staff had come off Whitley pay and conditions - by health service managers outside the tmst with whom the researcher had informal contact. In addition, the Director of Corporate Affairs, from CCHT, was undertaking a PhD on a part-time basis at the university in which the researcher was employed. She came to speak to the researcher about her PhD. In the course of the conversation, the concept of Strategy Project Groups was talked about. These appeared, to the researcher, to be an exciting innovation that might enhance the middle manager's role. Therefore on the basis of an interest in Strategy Project Groups and that CCHT appeared to have a progressive human resource strategy, the researcher negotiated access to the case study hoping it might illustrate more fiilly what an enhanced middle manager role constitutes and the conditions necessary for this. However, an enhanced role for middle managers in CCHT was not illustrated. Middle managers in this case study of human resource strategy were subject to conditions that meant they mainly carried out the role of implementing deliberate strategy and had limited discretion within this.

Following research in CCHT, another case study was brought to the attention of the researcher, which offered a potential illustration of an enhanced role for middle

[28] On similar grounds, Midlands City Hospital had also been approached. Access was initially granted but talks of rationalisation of hospital services in the city influenced their subsequent willingness to become involved in this study. The Director of Human

managers. A Personnel Manager from the coal industry, whom the researcher had brought into the university at which he worked, to provide a 'live' case study of change for MBA (Public Services) students, introduced the researcher to the Personnel Manager at Edwards Hospital. Following casual conversation, in which the subject of football provided the initial social lubricant, conversation moved to discussion of what Edwards Hospital were doing in the area of human resource sfrategy. From this conversation, the researcher was hopeful that Edwards Hospital represented a case to illustrate an enhanced role for middle managers that the researcher sought. This was based upon an approach taken by the Personnel function at Edwards Hospital towards strategic change, which sought to include middle managers in the formulation and implementation of strategic change in the area of human resources (see chapter 8).

In both cases of CCHT and Florence Hospital, access was negotiated with the Director of Human Resources who then took it forward for agreement with the Chief Executive. When this was confirmed the Director of Human Resources wrote to middle managers in operational areas and executive directors asking for their co-operation. Therefore the research may have appeared to be sponsored by the Human Resources Department to potential interviewees. Whilst it was the case that some feedback was offered to the Human Resources Department the researcher emphasised to interviewees that responses were confidential and that the process was one of academic research rather than consultancy.

Resources at Midlands City Hospital quoted the Chief Executive as commenting that the hospital had '*research fatigue*', and was unwilling to grant access to the researcher.

4.2.1(b) *The Case Studies - Business Planning, Marketing and Human Resource Policies and Practices as Strategic Change*

Strategy is often considered to be the high point of managerial activity and typically standard textbooks define it as follows: 'top management's plans to attain outcomes consistent with the organisation's missions and goals' (Wright et al, 1992: 3). In terms of what are considered strategic issues, certain 'hard data' decisions (for example, on product market position or resource allocations) tend to dominate the analytical literature (Ansoff 1965; Katz, 1970).

However, issues of strategic change may be more broadly defined. Johnson and Scholes (1997: 4-11), that mainstay text of undergraduate strategic management modules in UK undergraduate business education, set out the following characteristics of strategic decisions -

1. Strategic decisions are likely to be concemed with or affect the long-term direction of an organisation.
2. Strategic decisions are normally about trying to achieve some advantage for the organisation: for example, over competition.
3. Strategic decisions are likely to be concemed with the scope of an organisation's activities; does (and should) the organisation concentrate on one area of activity, or should it have many?
4. Sfrategy can be seen as the matching of the activities of an organisation to the environment in which it operates.

5. Strategy can be seen as building on or stretching an organisation's resources and competences to create opportunities or capitalise on them (Hamel and Prahalad, 1994).
6. Strategies may require major resource changes for an organisation.
7. Strategic decisions are likely to affect operational decisions and strategic architecture to put strategy into effect, such as Personnel policies and practices and marketing and advertising, may give organisations important advantages that are difficult to imitate.
8. Sfrategy can be thought of as a reflection of the attitudes and beliefs of those who have most influence in an organisation.

Johnson and Scholes (1997) also highlight the different levels at which strategy exists beyond the corporate level. In addition to the overall purpose and scope of the organisation that constitute corporate strategy, there are business unit strategies and operational strategies. Business unit strategy is about how to compete successfully in a particular market - for example, what new opportunities can be identified or created in markets; which products and services should be developed in which markets; and the extent to which these meet customer needs in such a way as to achieve the objectives of the organisation such as, measures of efficiency. Operational sfrategies are concemed with how the component parts of the organisation in terms of resources, processes, people and their skills are pulled together to form a strategic architecture which will effectively deliver the overall strategic direction.

Of the various schools of strategy described by Whittington (1993), the Processual School of strategy (Whittington, 1993) offers a perspective of strategy adopted in this

thesis (see chapter 2). The Processual School emphasises more forcefully the point made by Johnson and Scholes (1997) that sfrategic change does not only take place at the corporate centre but may take place at other levels of the organisation. In the Processual School strategy is viewed as involving issues of both content and process, as being emergent as well as deliberate, where intended and realised strategies vary from each other, and as existing on different levels (Mintzberg et al. 1998).

One of the exponents of the Processual School, Quinn (1978) broadly defines the strategic change process. In his study, executives identified other 'soft' changes, as opposed to 'hard data' decisions that have at least as much importance in shaping their organisation's strategic posture. These were - overall organisational stmcture or its basic management style; relationships with the government or other extemal interest groups; acquisition, divesture or divisional control practices; intemational posture and relationships; innovative capabilities or personnel motivations as affected by growth; worker and professional relationships reflecting changed social expectations and values; past or anticipated technological environments (Quinn, 1978: 9).

Further Quinn (1978, 1980, 1982) also identified different levels of strategy. Of importance in relation to the content issues considered in this thesis is the notion of strategic subsystems, which attack a specific class of strategic issue ouflined above and which are blended incrementally and opportunistically into a cohesive pattem that becomes the company strategy. As Quinn *{ibid.)* observes, 'sfrategic decisions do not lend themselves to aggregation into a single massive decision matrix where all factors can be treated relatively simuhaneously in order to arrive at a holistic optimum (Quinn, 1978: 15). Reflecting Mintzberg and Waters' (1985) notion that strategy is a

pattem in a stream of actions or decisions, Quinn (1978, 1980, 1982) emphasises that strategic change takes place in strategic subsystems, such as the overall organisational stmcture subsystem, product line positioning subsystem and employee relations subsystem:

'Each of these subsystems to a large extent has its own peculiar timing, sequencing, informational, and power necessities. Different subsets of people are involved in each subsystem strategy ... [and] each subsystem's strategy is best formulated by following a logic dictated by its own unique needs' (Quinn, 1980: 59).

On the basis of this description of strategic change, the unit of analysis for strategic change may usefully be seen as that of a strategic subsystem rather than overall corporate strategy, particularly as it is the former rather than at the latter strategy level that middle managers' influence is most likely to be seen.

Within the Processual School, Pettigrew and Whipp (1991) add further to this broader or more 'holistic' (Pettigrew and Whipp, 1991: 26) understanding of sfrategic change. They also highlight the multi-level analysis of strategic change. They describe three essential dimensions of strategic change. Firstly, there is an element of content that is commonly conceived as strategy - for example, assessment and choice of products and markets, objectives and assumptions and targets and evaluations. Secondly, there is context, described as either intemal (eg. resources, capabilities, culture, politics) or extemal (economic/business, political, social). Thirdly there is an element of process - for example, change managers, models of change, formulation/implementation, pattem through time. Pettigrew and Whipp *{ibid:* 27) sfress that:

'The point to appreciate is the richness of these contexts and their simultaneous shaping of strategic change. The hallmark of the processual dimension is that strategy does not move forward in a direct, linear way nor through easily identifiable sequential phases. Quite the reverse, the pattem is seen as continuous, iterative and uncertain.'

On the basis of their previous work, Pettigrew and Whipp (Pettigrew 1985; Whipp, 1986, 1987) argue that, 'even single strategic decisions over, say, a major project or product change, are not franslated into action immediately' (Pettigrew and Whipp, 1991: 31) and, 'given the powerful intemal characteristics of the firm it would be unusual if they did not affect the process: more often they fransform it' (Pettigrew and Whipp, 1991:31).

Therefore taking a view that strategic change is Processual (Whittington, 1993) (see chapter 2) and informed by the definitions above of strategy, suggests that investigating strategic change at a sub-system level may usefully illuminate the influence of middle managers in strategic change since strategy is best seen as process and this involves streams of activity across time, which actors from across the organisation, besides executive management, are involved in.

On this basis investigating the influence of middle managers in the strategic subsystems of management education, business planning, marketing and human resource management is relevant. Business planning and marketing activity, for example, which are represented in chapters 5 and 6, are strategic because resource allocation decisions into which this process feeds may significantly influence services offered by the case study hospital tmst - Florence Hospital.

Similarly, the human resource policies and practices examined at CCHT and Edwards Hospital may be usefully examined as a strategic subsystem since skill mix of healthcare teams, recmitment and selection of individuals into those teams, management education (also considered at Florence Hospital) and the way in which individuals' performance is incentivised through pay for example, are likely to affect what activities an organisation is engaged in, take account of customer definitions of quality and resource constraints imposed by government, stretch or lever the organisation's resources (Hamel and Prahalad, 1994) and more generally form strategic architecture that is difficult to imitate, thus ensuring some advantage over any competitors.

To summarise the unit of analysis is one of strategic change at the strategic subsystem level, in which the influence of middle managers is investigated.

4.2.1 **(c)** ***Process of Successive Case Studies***

Given the emphasis upon a process of successive case studies, it is desirable to elaborate upon the way in which cases were selected and the process by which findings from each case were built upon during research in the next.

In this thesis, the five cases were selected sequentially, each building on the preliminary findings from the prior case(s). To carry out five cases simultaneously is difficult, if not impossible, because of resource consfraints. Unlike Pettigrew et al (1992), who gathered data through a number of team members, there was but one researcher involved in the production of this thesis. Therefore, each case was studied

as if it was a stand-alone entity but reflected insights and understanding gained from one case applied to the next. Therefore, the series of successive cases allowed the researcher to take advantage of increased experience to achieve higher levels of understanding and allowed the researcher an increasingly rich understanding of the phenomenon (Eisenhardt, 1989).

The interventions upon which the research focused in Florence Hospital, CCHT and Edwards Hospital were chosen on the following basis. In Florence the researcher's concem lay initially with management development. This was felt to illuminate the 'contested terrain' (Edwards, 1979) of the NHS. Following the initial theoretical proposition that middle managers were likely to resist strategic change, such as that promoting general management, which was driven in a top-down manner, management development was felt to have a key role in the promotion of a general management ethos (Albert and Silverman 1984a, 1984b, Brown 1995, Trice and Beyer 1993, Williams et at, 1993). While this is not subsequently represented in detail in this thesis, it provided food for thought and this led to some adjustment of the original theoretical proposition. In such a process of successive cases, theory building took place (Eisenhardt, 1989).

The two other cases within Florence, following analysis of the management education case, were business planning and marketing. Both the business planning and marketing cases promised to illuminate the role of the middle manager in the realisation of strategic change beyond that of merely resisting deliberate change. The production of business plans was necessary for the granting of tmst status originally yet the concept of business planning was one that drew heavily upon private sector

practice. They inscribed performance indicators upon the middle managers. In this middle managers were encouraged to give up traditional modes of attachment and replace them with a frame of reference for organisational action which foregrounds the calculus of efficiency and action (Clarke and Newman, 1997). Therefore, even more so than management education, business plans were also likely to represent contested terrain (Edwards, 1979), but also be an area where middle managers might exert some upward influence upon strategic change. Regarding the third case, on one hand the marketing intervention represented an attempt to orientate middle managers towards the internal market and therefore might also be resisted, but on the other, the strategy was emergent to some degree and also appeared to offer the opportunity for an enhanced middle manager role. Both business planning and marketing cases were also expected to illustrate constraints, particularly those of medical group power and central government policy, upon the role of middle managers in strategic change.

In the subsequent case studies, CCHT and Edwards Hospital, one issue was focused upon - that of human resource strategy. In theoretical terms. a focus upon one issue facilitated the exploration of context upon process. That human resource sfrategy was the issue selected was because it promised to illuminate the impact of centre-periphery relations upon the role of middle managers in strategic change, both at the level of the relationship between central government and tmsts and at the level of the relationship between executive management and middle management within tmsts. The choice of issue was also guided by pragmatic considerations because the researcher had previously worked in human resource management (at the Rover Group and with West Birmingham District Health Authority) and had academic knowledge of human resource management in his role as a university lecturer.

4.2.1 (d) *Leaving the Field*

While the gaining of access to fieldwork was an important issue, it is also worth providing a brief comment upon 'leaving the field'. Like all other aspects of field relations it must be negotiated (Hanunersley and Atkinson 1995). In some cases this can be negotiated when gaining access to the case. This is more appropriate when the research design is pre-defined to a large extent. For example, in the cases of CCHT and Edwards Hospital where the number of interviews, the interview respondents and the time period over which interviews were to take place was negotiated in advance, so too was disengagement from the field and feedback. In these cases it was agreed feedback was to take place via a 'network day' which was to disseminate research findings about the role of the human resources department in the management of change to a wider group of NHS managers beyond the case studies. The sponsors from the case studies were invited to this.

However, where the research is largely inductive, it may be difficult for the researcher to decide in advance on the length of time to be spent in the field. Here disengagement from the field may take place during the latter stages of fieldwork and may be less formalised. In the case of Florence, no specific time schedule had been negotiated and the researcher 'hung around' for a period of two years before disengaging in September 1997. The management development progranune had wom itself out and the marketing activities at Florence were being scaled down in the face of merger between Florence and Midlands City Hospital. The business planning cycle had also been observed for two years and documentation gathered for business

planning prior to this. There had also been three rounds of interviewing in Florence. Thus, data categories appeared relatively saturated and this combined with pragmatic considerations such as time and the exit of key informants from the organisation led to the researcher's decision to exit the organisation.

Regarding the latter consideration, the decision to disengage was facilitated by the exit from the organisation of the Chief Executive with whom negotiation had been negotiated originally, and the impending exits of the Organisation Development Manager who was a key sponsor to a purchasing health authority, and the Service Manager for Medical Services, who helped the researcher find his way around the hospital, to the Audit Commission. Before disengaging from the field in Florence the researcher merely announced his intentions to the Organisation Development Manager and the Service Manager and scaled down his attendance in Florence over a period of two months. Prior to leaving the field there was no formal feedback given to Florence nor was it asked for.

4.3 The Research Techniques

In this section, following on from the outline of the process of research provided in the introduction, the intention is to provide more detail about the three research techniques employed - the semi-stmctured interview, observation and documentation collection. In addition, as well as describing and rationalising the use of the research techniques, this section will describe the location of the researcher in producing the data - that is, it will refelct upon the contexts in which the data was produced.

4.3.1 The Interview

There are three important issues in cormection with the interview as a research technique, which were revealed during the course of the research. Firstly, there is the question of the extent to which the interview should be stmctured. Secondly, some comment needs to be made about the selection of interviewees. In particular, given the difficulties of definition of the middle manager described in section 1.1.1, which contribute towards a vagueness noted by Dopson and Stewart (1990, 1993) and Pinnsonneault and Kraemer (1993) about who middle managers are in academic studies, some comment is made about the identification of middle managers in the case studies selected. Thirdly, there is the nature of the interview itself This latter issue concems the relationship between researcher and those who are being researched. It is an issue of concem generally and is further discussed in connection with observation as a research technique (see section 4.3.2).

4.3.1 (a) *Interview Structure*

The use of the interview was prevalent within all five case studies examined. However, the characteristics of the interview varied with the stage of the research. This is apparent in the interview schedules documented in appendices A to E. While these represented a guide for the interviewer, rather than to be slavishly followed, the questions asked moved from more general questions about the feelings and responses of middle manager to change to more specific questions about how middle managers contributed towards to strategic change and characteristics of inner and outer context

of the case study organisations that facilitated or inhibited the influence of middle managers upon sfrategic change.

For example m first stage interviews in Florence Hospital on one hand, questions asked were typically broad in nature. Respondents were asked at this stage to describe what changes they have seen in the hospital and how they felt about these changes. As Kvale (1983) states:

'[the purpose is to] gather descriptions of the life worid of the interviewee with respect to interpretation of the meaning of the described phenomena' Kvale (1983: 174).

On the other hand, there were questions specifically about the first case study of management education since another of the purposes of these interviews was to guide subsequent data gathering in this case.

The second set of interviews carried out in Florence Hospital discussed the issue of management development to some extent, but focused mainly upon the second case study of business planning. In these interviews the researcher posed relatively open questions about business plarming before moving on to pose some specific pre-determined questions about this intervention. In contrast the third set of interviews in Florence Hospital were stmctured to a greater degree following an iteration of observation and interviewing and focused on the third case study of marketing with some discussion of business plarming. They exhibited a greater concem to validate the second order interpretation of the strategic change process by the researcher. In the two subsequent case studies - CCHT and Edwards Hospital - one substantive issue was focused upon rather than change in general. The intention here was to elaborate

upon the emerging theory and probe responses deeply in a search for negative cases against which the theory could be judged.

When preparing to conduct interviews in the latter stages of the research, Kvale's text (Kvale, 1997) in particular provided a source of advice that guided the stmcture and process of interviewing. The semi-stmctured interview approach was adopted so that 'it has a set of themes to be covered as well as suggested questions. Yet at the same time there is an opermess to changes of sequence and forms of questions in order to follow up answers given and stories told by subjects' (Kvale, 1997: 124). Also, as described later in this chapter the form of analysis was one of 'interpreting as you go - considerable parts of the analysis are pushed forward into the interview situation itself (Kvale, 1997: 178).

4.3.1 (b) *Sample of Interviewees*

4.3.1 (b) (i) *Who are the Middle Managers?*

While a specific definition of the middle manager was laid out in section 1.1 as, '[those] within divisions, directly involved in planning and co-ordinating the the production of services that are specific to their own units' (Smith, 1997: 23), it was also noted that many academic studies have found difficuhy in delineating differences between junior, middle and senior managers (Pinnsonneauh and Kraemer, 1993). Such problems have been further exacerbated by de-layering of middle managers noted in section 1.3.1, which compress an organisation's managerial stmctures and might render the identification of a distinctive middle management group difficult.

Such forces for de-layering are evident in the NHS (see section 3.4.4) and are illustrated in the case studies, particulariy Florence Hospital and CCHT.

Further, in the NHS the situation is complicated by the existence of the medical group and government policy that attempts to integrate them into the managerial process (see section 3.4.5(b)) via posts of Clinical Director or Medical Director. However, while members of the medical group take up these posts, they exhibit varing degrees of proactivity in these roles and in some cases, merely represent their colleagues and retain a power of veto over decisions more generally, rather than manage the directorate in a broader sense (McKee et al 1999). In these cases they may not represent 'linking pins' (Likert, 1961) between the vision of executive management and the operations of health care more broadly. As such, they may not take on a middle manager role. In other cases, as noted by McKee et al (1999), they may take on a role where they proactively manage all professional and non-professional groups within a directorate. In this case they can be considered to be middle managers. McKee et al *{ibid.)* note that their orientation towards a middle manager role is mainly determined by their background, particularly whether they have been previously exposed to a management role, and their stading amongst peers.

As well as variations in a Clinical Director's make-up that influence whether or not they can be considered to be a middle manager, there are variations in tmst stmctures and managerial philosophy that influence whether Clinical Directors merely represent their peers and retain a power of veto otherwise or whether they take on a general management role, which is more reflective of a middle manager as defined by Smith (1997). For example, in Florence Hospital, the former was revealed in interviews,

while in Edwards Hospital, where there was a larger number of directorates and a more collaborative managerial arrangement between the Specialty Manager, Nurse Manager and Clinical Director, the latter was revealed. Therefore, the researcher interviewed the two Clinical Directors responsible for both clinical areas in which data was gathered at Edwards but only interviewed 2 of the 7 Clinical Directors in Florence Hospital. In the latter case, data was gathered mainly about the constraint that medical group power might impose upon middle manager influence, while in the case of Edwards Hospital, concem lay with the role of Clinical Directors as middle managers as well as medical group power.

To summarise, in Florence Hospital, the middle manager group was viewed as that of General Managers and Service Managers in the main, rather than Clinical Directors, within directorates. Their identification was aided by their nomination to participate in the middle manager development programme. In Edwards Hospital the middle manager group was viewed as that of the Nurse Manager (in clinical areas only), Speciality Managers (in clinical and non-clinical areas) and Clinical Directors (in clinical areas only). The role of the Business Manager in Edwards was merely that of fiimishing the directorate management team with information rather than managing the operations of the directorate and therefore, in this case, they were not considered to be a middle manager. There were no such identification problems in CCHT, where the middle manager group was considered to be Locality Managers in the main. In this case, because of their location within the corporate centre rather than within the Operations Directorate, Assistant Directors were not considered to be middle managers. To a large extent, therefore, decisions about who should and should not be

included in the middle manager group is a matter for the individual researcher given the nuances of organisational contexts.

4.3.1 (b)(ii) *Florence Hospital*

As far as sampling of participants was concemed in the Florence Hospital and the other two cases, Burgess (1984) suggested informants need to be selected using the researcher's judgement to portray aspects of the social situation, and this was exercised in line with advice from organisational insiders. In the three case studies in Florence Hospital, this was guided by the participants on and other stakeholders around the management development programme under study initially. In the Florence Hospital 14 relatively (compared to subsequent interviews) open interviews with General Managers and Service Managers were undertaken initially in the first stage of interviewing (see Appendix A for schedule). Given that there were seven clinical directorates at Florence, these represented almost all the General Managers and Service Managers in the tmst (some directorates, such as Medical Services had more than one Service Manager). These were taped and transcribed. Following analysis these provided a framework for the first period of observation.

In a second stage of interviews at Florence (see Appendix B for schedule), a further 25 interviews, of a semi-stmctured nature were undertaken with middle managers (General Managers and Service Managers), senior managers and others who sought to manage the middle management resource (for example, the Organisation Development Manager). Included in this phase of interviewing were three representatives of the medical group (2 Clinical Directors of the 7 in total and the

Medical Director, who was later to become acting Chief Executive). During these interviews notes were taken. The reason for this was that they were of a relatively informal nature and concemed with elaborating upon the understanding of change so far reached by the researcher.

In a final third stage (see Appendix C for schedule) 30 semi-stmctured interviews were undertaken at Florence. These elaborated fiirther upon issues raised in the first and second stages of interviewing. 4 of the 5 General Managers were interviewed. 2 had been interviewed in the first stage of the data gathering process. The researcher was advised by the Organisation Development Manager that it would be unwise to interview the Accident and Emergency Manager because of recent upheavals in the area and subsequent insecurity of staff. 11 Service Managers and 5 Ward Managers were interviewed. 5 of the Service Managers had been interviewed in the first stage of the data gathering process and 2 of the Service Managers had been workshadowed for one day each to gain understanding of the context of their jobs. All 11 Service Managers had been interviewed in the second stage interviewing process. Interviews also took place with the executive directors at this stage apart from the Finance Director. Again the Organisation Development Manager advised that restructuring in this area meant interviewing was inappropriate. 2 of the executive directors had been interviewed in the second stage interviewing process. In addition, others who sought to manage the resource of middle managers were interviewed from inside the organisation - for example, Organisation Development Manager, Clinical Effectiveness Manager, Business Development Manager - as well as from outside the organisation - for example, marketing consultant, lead facilitator for the management education programme aimed at Service Managers. Finally, 2 Clinical Directors and

the Medical Director were interviewed. Apart from the Clinical Effectiveness Manager, all of these respondents had been interviewed in the second stage interviewing process.

One notable omission from this final stage of interviewing was a response from the Chief Executive. The Chief Executive declined to make himself available for interview because of the sensitivity and amount of his time taken up by the proposed rationalisation of services in the city. However, at a later date he subsequently agreed to be interviewed having moved to another post at South Midlands Infirmary. This proved fortuitous for the researcher as analysis of the final set of interviews was complete by this time and a number of important questions had been raised. The departed Chief Executive was best placed to answer these and could do so from outside Florence. This final set of interviews, including the interview with the former Chief Executive, were taped and transcribed.

4.3.1(b)(iii) *CCHT*

In the case studies following those carried out at Florence Hospital interviews were also the main research technique used to gather data. In both cases interviews were taped and transcribed. In CCHT and Edwards Hospital the Human Resource Department guided selection of informants, but followed criteria laid down by the researcher. Selection of respondents in CCHT was less of a problem because it employed relatively few middle managers (18), and selection was made on the basis of availability during a certain time period. In CCHT 20 semi-stmctured interviews were carried out to complement documentation that was gathered - for example,

human resource strategy document, business plans, training plans. Interviews were carried out with all executive directors in post. This included the Chief Executive and Director of Human Resources and the Medical Director (6 interviews in total). It should be noted that the Medical Director in this tmst had a dental background because the tmst did not directly employ GPs. In addition, interviews took place with the non-executive director with responsibility for personnel issues, 2 personnel officers, and 11 middle managers (3 Assistant Directors, 5 Locality Managers, 2 specialist clinicians who manage teams, 1 Health Centre Manager).

Interview questions (see Appendix D for schedule) were identified following analysis of the human resource strategy and exploratory conversations with the Director of Human Resources and Management Development Manager. The issues identified - local pay, management development, competence-based recmitment, skills mix, and project management - represented issues which the Human Resources Department in the case study had varied impact upon.

4.3.1 (b)(iv) *Edwards Hospital*

In the case of human resource strategy at Edwards Hospital, selection of respondents was problematic given the size of the hospital. A slightly different approach to the choices of interviewees and content of interview question areas (see Appendix E for schedule) was taken in the second of the subsequent case studies where 20 interviews were carried out. As Edwards Hospital is such a large and complex organisation the decision was made to focus upon 3 areas of the hospital - 2 clinical and a non-clinical area. These (and potential interviewees) were selected following an exploratory

meeting with members of the Human Resource Department. The areas were selected on the basis that they exhibited varying characteristics whose influence upon human resource strategy the researcher wished to explore - for example, sensitivity to market forces, medical group representation. The areas studied were Oncology, Theatres and Operational Services. 12 middle managers in these areas were interviewed. These included the 2 Clinical Directors for the clinical areas selected as sites for data-gathering. Alongside these, 3 Personnel Advisors, the Organisation and Management Development Advisor, the Personnel Manager and the Director of Human Resources were interviewed. One other executive director (Director of Nursing) and the Acting Chief Executive, who also ftilfilled the role of Medical Director, were also interviewed. The limited number of executive directors who were interviewed in comparison to the other cases was a decision made on the basis of pohtical sensitivity to secure access to Edwards Hospital. Here, the Director of Human Resources, through whom access had been gained for research, did not want findings percolating outside the Human Resource Department and 'advised' the researcher that interviews with the executive management group should be limited.

4.3.1 (c) *The Nature of the Interview*

In all 5 case studies the nature of the interview was one of a qualitative interview. The interview was also understood from a specific epistemological and ontological perspective. It is recognised that the interview can be a topic for analysis as well as a resource for analysis. The way in which the status of the interview is regarded in this study emphasises the latter - the interview as a resource for analysis. Taking advice

from Melia (1997), the researcher recognises the problematic status of the data but 'settles' for the interview data as telling a plausible story.

Kvale (1996) re-conceptuahses the interview as the 'Interview' in seeking to emphasise the constmctive nature of the knowledge created in the interaction of the partners in the interview conversation. Such a re-conceptualisation resonates with the researcher in this case. Thus, whilst emphasising the interview data as a resource, the interview is recognised as a stage in which knowledge is socially constmcted between the interviewer and interviewee. It follows from this that there be some necessary reflexivity in the account produced by the interviewer as a co-constmcter of that account. Therefore necessarily there will be a commentary, which reflects the nuances of the qualitative interview as a craft.

An illustration of the production of knowledge through interaction came in an interview with a nurse manager at Edwards Hospital. At the end of the interview the nurse manager remarked that; *'/ get the feeling that you don 't think the human resource function has much of a role in the health service'*. This amused the researcher, since in the interview immediately prior to this, he had been asked of his view of the human resource function by the respondent and answered 'genuinely' that he thought they carried out an important role very well. Somehow, during the course of the interview, the opposite viewpoint had been constmcted. In another case, the respondent asked, *'Am I giving you what you want?'* The researcher's response was typically, *'I'm interested in how you see things so whatever you say is relevant*'. Here again we see that both respondent and researcher constmct the interview as the former seeks to 'please' the latter.

The nature of the interview process as involving craft skills, particularly that of sensitivity to the context in which research was taking place, was evident at all stages. Particularly important was that the researcher be sensitive to the way in which he presented himself to others. Within this he considered the way he dressed and the expertise (or lack of expertise) he presented to respondents and gatekeepers. Dependent on who was being interviewed the researcher adopted appropriate modes of dress and presentation of expertise. This was important given the symbolism of dress codes within a hospital (Preston et al, 1996). For interviews with executive management a suit, shirt and tie was wom. With nurse managers (Service Managers, General Managers, Locality Managers) a casually smart mode of dress, - for example, open-necked shirt, chino trousers - rather than a suit and tie, was adopted so as to distance the researcher from 'management' to which respondents may have been antagonistic.

Similarly the researcher was sensitive to the effect of any expertise presented to respondents. For example, in initial access negotiations with the Director of Human Resources and Organisation Development Manager at Florence, the researcher showed detailed knowledge of the management learning process to estabhsh his legitimacy. Such knowledge was based upon a previous 'life' as a Management Development Advisor in a district health authority. With those managers who operated within the clinical or operational directorates rather than the cenfral directorate, the researcher attempted to show knowledge of what clinical processes involved by use of technical language such as primary care and patient-focused care, and similarly establish his legitimacy within the short space of time offered in an

interview situation. However, sometimes it was helpful to feign ignorance in eliciting versions of events from respondents - for example, in defining what 'marketing' was. The important point emphasised in presentation of expertise or otherwise is that it was a question of judgement by the researcher which often involved a 'snap' decision in the course of fieldwork.

Another important issue within the interview was the influence of the stance taken by the researcher and the profile adopted (Burgess 1984). Initially, for example, the researcher acted as a 'stone wall' in not conveying any impression to respondents in terms of verbal and non-verbal cues. However, early interviews appeared 'dead'. It was found that more interesting and useful responses were gained if the researcher made the interview pleasing to the person being interviewed - for instance by reflecting back substantive and emotional content of the interviewee's response. This often encouraged interviewees to 'correct' the interviewer or to elaborate upon points made. For example, when eliciting responses from middle managers about the management development programme, the researcher often reflected back their feelings of 'distress' in moving from a role where they were formerly 'a nurse who manages' to one where they are 'a general manager with a nursing background'.

In some instances respondents were very cagey in their responses. Their non-verbal communication suggested they were wary of the purpose of the interview. Such respondents seemed relaxed when more specific questions were asked. Such nuances of the interview data gathering process were regarded as a source of data and brief notes were taken where necessary to complement interview transcriptions. One possible interpretation of such 'cageyness' was that they preferred the objectives of

the research to be transparent in what represented a rather insecure workplace for them.

Other nuances of the interview suggested attempts by respondents to project their identity. For example, some sought to constmct themselves as 'general managers' by prominently displaying management text-books and pointing them out to the researcher. Others emphasised their nursing background by a nurse uniform being placed on a hanger on the back of their door and emphasising that they regularly went out on the wards and did *'real work'*.

4.3.2 Observation

Observation was a particularly strong feature of the first case study at Florence Hospital - the management education programme - but was also carried out throughout the research study. There are a number of issues the reader may note, which have been discussed in previous sections of the methodology chapter, that are also raised in relation to the technique of observation. Firstly the nature of qualitative research as a craft skill is illustrated when data gathering via observation. Secondly, the impact of the relationship between the researched and researcher is illustrated. However, before we go on to discuss these two related issues, it is worth commenting upon the relationship between any literature review carried by the researcher and the data gathering process.

The literature review was not a one-off process carried out at the start of the research study. Within the first case of management education, observation was framed by an

initial review of literature around sfrategic change combined with respondent's perceptions of change generally, as revealed in the first stage exploratory interviews. This overcame a potential problem that the researcher may have been overwhelmed by data. Subsequent iterations of observation, interviewing and analysis in the other four case studies were complemented by an on-going review of the relevant literature as the focus narrowed (see section 4.4 for fiirther discussion of how elements of research are intertwined).

The researcher set out to learn first hand, to collect rich data, based on observations in natural settings. Care was taken to record descriptions rather than mere impressions (Silverman 1993). Observation was carried out, for instance by work shadowing middle managers, by attending meetings in which middle managers and other stakeholders were involved such as patient-focused care meetings[29], and by attending other rituals such as management development workshops and development centres.

Again the importance of the craft skills of qualitative research were evident. For example, the researcher had to adapt to different types of people and situations (Waddington 1994). An illustration of this came in the development workshops at Florence, for instance, where middle managers first came across the researcher. Here, the researcher adopted a posture of nonchalance, where he looked out of the window so that he appeared to be uninterested in the middle managers conversation. However, while adopting this posture, he listened intently to interactions between participants. Then during the next activity, of less interest to the researcher, a period of great concentration followed as the researcher made notes relating to the previous activity.

[29] Patient-focused care involved 're-engineering' the process by which the patient received healthcare so that different professions and processes were grouped around the patient, often in the same physical location. For example, instead of patients

At other times the researcher could not help but pick up a pad and take notes whilst an interaction of relevance was going on.

On one occasion, this caused a particularly interesting response from those being observed, which was regarded as a source of data. Here, in a development centre activity, it appeared that participants took a brief 'time out' from a heated discussion, as they became aware of the note taking by the researcher. Following this the heated discussion continued unabated, in this case directly about their, *'discomfort felt between managerial and professional roles'*. However, later in the day the participants 'joked' that they did not tmst the researcher.

On another occasion of observation during a subsequent development centre, those being observed expressed a contrasting view. Here participants expressed the view that, *'you are not one of them* [them being management and the researcher being a management spy?]', and could therefore be allowed to observe overtly without the participants becoming unduly worried. The point to be gleaned about these illustrations is that sensitivity is required to context and on-the-spot decisions need to be made about what might be considered to be mundane issues, such as when to take notes.

The work-shadowing undertaken by the researcher also illustrated some important issues around data-gathering via observation. In one instance, the researcher followed the activities of the typical working week of a middle manager who was defined as exhibiting *'champion Service Manager'* behaviour by the Human Resource

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being sent across the hospital for an X-ray, where possible, they would be X-rayed near the location in which they were receiving their consultation.

Department. This involved merging into the background as the manager answered phones, dealt with team members and other parties coming into her office for discussion. The 'problem' lay not so much with the manager but the other parties with whom she interacted as they took account of the researcher's presence in offering a performance of their role. At its most obvious this involved nurses hesitating before communicating with the Service Manager so that the researcher could be introduced. In other instances the work-shadowing activities were akin to participating in a 'fly on the wall' documentary. One of the half day work-shadowing activities was spent solely observing a lengthy meeting between a Service Manager and her team members at Florence. At the start of the meeting the researcher was introduced and the purpose of his research outlined. After a short settling down period the Service Manager and her team appeared to no longer notice the researcher's presence. Evidence of this came in a statement by one of the ward sisters involved. She apologised, *'we forgot you were here'*, when the researcher was the only one in the room who was not offered a cup of coffee and a piece of cake to celebrate someone's birthday, during a break. The Service Manager agreed with the researcher's interpretation of this incident that the impact of the researcher was diminished because the arena for observation was one in which considerable time was spent. Such illustrations provide evidence that engagement with organisational members for a lengthy period was potentially beneficial in yielding additional data because of tmst built up by the researcher with those organisational members (Waddington, 1994).

4.3.3 Document Collection

The stress put upon in-depth interviewing and observation did not mean that other techniques were ignored. The study of archival material and document analysis was seen as useful. For example there were problems associated with retrospective commentary on the development of the management fraining programme by respondents whose memory of events was often fuzzy. The various documentary records such as memos, minutes of meetings, and extemal correspondence with the training provider provided another source of data about historical events with which to triangulate data gleaned from interviews. As Forster (1994) suggests, data gleaned from documentary sources is often more comprehensive than the material which a researcher who is new to an organisation could obtain from interviews or questionnaires.

In particular documentation proved usefiil for analysis of the business planning process in Florence Hospital. The researcher analysed business plans over a four year period (1994/95 to 1997/98) of the Surgical Services Directorate, the Medical Services Directorate and the Critical Care Directorate. These directorates were selected in particular for analysis of business planning documentation because they represented directorates for whom the impact of the intemal market varied (this was evident in interviews with General Managers and Service Managers).

However, the researcher has found problems with the use of organisation documentation. Given the amount of documentation produced in a modem organisation it is tempting to be indiscriminate in the paperwork that is collected.

Thus the researcher glanced through the documentation before making a decision to subject it to detailed analysis. In addition, it is relevant to consider the context in which the documentation was produced. In relation to this it was difficult to imagine the political processes which went into the production of data in many instances. In an illustration of this, in a conversation with a Service Manager, it was revealed that the documentary outcomes of a meeting around Patient-Focused Care were a result of imposition by executive management in the meeting and not something agreed to others present in the meeting at the time. Again the researcher should be sensitive to the 'reality' which documentation reveals. Whilst valuable, it often offers data relating to formal aspects of the organisation only. For instance, human resource policy as enshrined in documentation at CCHT often bore little relation to human resource practices at operational level.

4.4 Data Analysis

Critics of qualitative research claim there is insufficient detail in reports produced about how data was analysed (Bryman and Burgess 1993). Others claim that a 'huge chasm often separates data from conclusions' (Eisenhardt, 1989: 539) that necessitates some description of how the researcher 'got from 3600 pages of field notes to the final conclusion' (Miles and Huberman, 1984: 16). Yet it is the analysis of data, as much if not more than the data collection, that makes up qualitative methodology (Silverman, 1993). This section is intended to address such criticisms. How, by whom, and when data analysis is carried out is emphasised as an important concem of qualitative research. The adoption of certain research techniques such as observation do not in themselves mean that a qualitative approach has been adopted.

One cmcial point to be made is that this research study does not regard data analysis as a distinct phase separated from data gathering (Burgess, 1984; Bryman and Burgess, 1993). The importance of such a perspective to social research has been well summarised by Bechhofer (1974):

'The research process then, is not a clear cut sequence of procedures following a neat pattem, but a messy interaction between the conceptual and empirical world, deduction and induction occurring at the same time' (Bechhofer 1974: 73).

As Bryman and Burgess (1993) recognise, the difficulties involved in doing research and writing about it are vividly portrayed through the use of the word 'messy'.

It would be misleading to suggest the description in this thesis wrote itself The research presents and orders the data according to what the researcher thinks is important. Further, in conducting the study, the researcher has made decisions about what to observe, ask about and record. These decisions determine what is described and how it is described. The purpose of a theoretical study is to understand or explain features of social life beyond the particular people and settings studied. Thus, the researcher actively points out what is important to their audience. To this end descriptive data is provided to illustrate the theories and concepts and to convince readers that what they say is tme (Taylor and Bogdan, 1984). In line with this approach it is appropriate to make some detailed conunents about the data analysis in this study.

In particular, in this section 4.4, the researcher would like to draw the attention of the reader to three issues - the relationship between data gathering and data analysis, the

relationship between the review of management literature and data analysis, and the process by which the researcher's interpretation of findings was validated.

4.4.1 Relationship Between Data Gathering and Analysis

There was an iterative process of data gathering via observation, documentation and interviews with data analysis. The generation of concepts which occurs in this study was an important aspect of the qualitative research approach. Bogdan and Biklen (1982) provide some preliminary analytic strategies during data collection, which the researcher engaged in during the process of concept generation. Such strategies included - forcing oneself to narrow down the focus of the study, continually reviewing field-notes in order to determine whether new questions could fruitfully be asked, writing memos about what you have found out in relation to various issues (this tactic was modified by the researcher to include the production of 'bounded' papers for conference presentation or publication in academic joumals), and trying out emergent ideas.

It should also be noted that both within-case analysis and a cross-case search for pattems took place. The overall idea was to become intimately familiar with each case as a stand-alone entity. This process allows the unique pattern of each case to emerge before the researcher pushes to generalise pattems across cases (Eisenhardt, 1989).

4.4.2 The Use of Literature

Further suggestions of Taylor and Bogdan (1984) were taken on board. In particular a broad range of literature, beyond that which might be suggested by the initial research question, was considered as to whether it provided a better explanation of the change process than that which currently operated as a sensitising device. In addition more specific literature about NHS policy and attempts to manage change in the NHS was reviewed. The initial lens brought to bear was one that emphasised cultural change in the NHS. This was modified in the course of the study to reflect the research question reported here. Thus, for instance, strategic change literature relating to the role of the middle manager was found to better explain findings than the organisational culture literature.

Secondly, particular attention was paid to the development of a story line. The story line is the analytical thread that unites and integrates the major themes in the data. It is the answer to the question, 'What is this a study of?' Thus, while empirically the middle managers were the focus of the research, theoretically this took some time to evolve. The story line modified with the development of the research, so that it stood 'finally' as, 'The Role of Middle Managers in the NHS: The Possibility for Enhanced Influence in Strategic Change'.

4.4.3 Second Order Interpretation and Validity

The concepts reported in this research study represent a second order interpretation of organisational processes from the standpoint of the actors involved, collected and

retold by the researcher, also representing a certain standpoint (Geertz 1973). Such second order interpretation was pushed into the interview itself as the researcher sought to check his understandings of the change process. A good example of this occurred in the case of an interview with the Organisation and Management Development Advisor at Edwards Hospital. The researcher reflected back in an absfracted way the description of the change process by the Organisation and Management Development Advisor, by asking *'so, you try and shadow the concerns which are brought to you by the operational directorates. What you seem to do is intervene in areas which ask for your input and intervene in a way which meets your agenda in Personnel but also contributes to their problem-solving.'* On agreement by the Organisation and Management Development Advisor with the researcher's summary, fiirther examples were asked for to provide evidence that this was the case. Importantly this provided elaboration of theory and data as well as a check on interpretation.

The emphasis upon validity was one that sought to ensure a close fit between the data and what people actually said and did - that is, it allowed the researcher to stay close to the empirical world. While the approach taken in this research study sees data as shaped by the circumstances of its production and recognises that different data cannot be treated as equivalent for the purposes of corroboration and tiiangulation, various sources are highly complementary. Therefore a good case study may want to use as many sources as possible (Yin 1994). Hence observation, interviews and document collection were all utilised as data gathering techniques.

On one hand, it is commendable that texts have emerged that focus upon analysis of qualitative data (Miles and Huberman, 1984; Silverman, 1990; Strauss and Corbin, 1990). On the other hand, the process of codification of data which is explicated in Miles and Huberman (1984), for example, may be undesirable because the text that is cut out is then taken out of its natural context. It may be better that any codification is at a general level (Bryman and Burgess, 1993). Therefore, borrowing a categorisation from Kvale (1996) the approach to analysis in this study was 'meaning condensation' or 'ad hoc'. In this process, the researcher read and re-read written notes from observation and interviews, transcribed interviews and documentation to identify emerging themes, which he then considered during subsequent fieldwork. This was an iterative process.

A particular difficulty in generating and elaborating upon concepts was the problem of attaining a higher order of abstraction without compromising the authenticity of the data. Whilst a 'check' on interpretation was built into interviews, as described before, member validation was also used. As Bloor (1997) suggests, although member validation is problematic because data gathered is a product of the circumstances in which it was produced, it is still useful in an attempt to reconcile abstraction and authenticity. In the research study there were three subjects in particular at Florence who were used to elicit responses towards papers produced by the researcher. These subjects had particular characteristics, which enabled them to view the papers and the verbal explanation provided by the researcher at a relatively high level of absfraction. The first was the Organisation Development Manager who was undertaking an MA in Management Learning. The second was the Service Manager for Medical Services who was undertaking a PhD on a part-time basis examining absenteeism and the

psychological contract amongst nurses. The third was the Anglican Chaplain, who through his theological background and concem about the impact of the changes upon the emotional well-being of staff could provide a particular lens with which to view change. Again valuable elaboration of theory and data was generated as well as a check on interpretation. A particularly usefiil arena in which the interpretive framework generated and the authenticity of the data were checked and elaborated upon came in a presentation to health service managers, including the Human Resource Directors of CCHT and Edwards Hospital, at a 'network' day.[30] Interpretation was also checked and elaborated upon via publication following a refereeing process in academic joumals, academic conference presentation and feedback and informal discussions with academics studying similar issues (Currie, 1996, 1999a, 1999b, 1999c, 2000).

In addition a case study database has been created so that data collected is available to other researchers in an accessible format (Yin 1994). In principle, other researchers can review the evidence directly and are not limited to the written thesis. Alongside this, the final thesis contains enough data so that the reader of the report can draw independent conclusions about the case studies. In this manner, the case study database and the final thesis markedly increase the reliability of the entire research study. As Bryman notes about the typical ethnography:

'Field notes or extended transcripts are rarely available; these would be very helpful in order to allow the reader to formulate his or her own hunches about the perspective of the people who have been studied' (Bryman 1988: 77).

[30] Network days were organised by the Centre for Health Service Management at the University of Nottingham. The audience for these network days were health service managers and clinicians.The aim of the particular network day in question was to report

Further, conventional conceptions of reliability were not altogether ignored since a colleague who was undertaking a PhD in a department of psychology[31] was enlisted to discuss the interpretation of the exploratory interviews carried out at Florence Hospital by the researcher. As well as providing an assessment of reliability to date this process also provoked fiirther insight for the researcher in developing a conceptual framework. The importance of middle managers became more prominent in the researcher's interpretation of the role of middle managers in strategic change in the NHS as contrasts were provided by the psychology academic with her work in a manufacturing environment which analysed the implementation of 'just-in-time' practices. Her work suggested the role of middle managers was less important.

4.5 Reflections Upon Methodology

There are a number of issues raised in previous sections of this chapter that highlight the way in which the researcher influenced the gathering of data, particularly in the descriptions of the interview and observation as data-gathering techniques, which reflect some limitations of the methodology. These aside, there are some general points to be made about the methodological approach.

Firstly, while the thesis addressed an empirical research gap about the role of middle managers in strategic change, this meant there was less emphasis upon other important stakeholders, such as the medical group, executive managers and policy-makers. As such, given the empirical focus was upon middle managers' perceptions

research findings from studies carried out by academics in the School of Management & Finance. The researcher provided a report upon the role of the human resource function in NCHT and its interaction with middle managers.

[31] My thanks go to Maire Kerrin, Department of Psychology at University of Nottingham for reading my exploratory interview transcripts and engaging in discussion.

of their involvement in strategic change, the thesis could be said to represent a partial picture of strategic change. However, it has attempted to deal with consfraints imposed by the medical group, executive management and policy-makers upon middle manager, both theoretically and empirically, but more research may usefiilly be carried out from the perspective of stakeholders other than middle managers, as noted in section 9.4.

Secondly, also as noted in further research (section 9.4) case studies are illustrative of themes raised in the academic literature rather than generalisable in a statistical sense (Yin, 1994). While case studies provide richer data that takes into account particular organisational contexts, this study may be usefiilly complemented by a wider survey across tmsts utilising constmcts developed from the rich data so far produced.

Finally the inductive approach adopted was time-consuming. Much of the data gathered in the early stages of the research study was under-utilised following the development of the research question and the choice of case studies - for example, 3 days observation at Patient-focused Care meetings is not represented in this thesis. Connected to this was that the gathering of data and its analysis, utilising academic literature, ran alongside each other in an iterative fashion. More efficient data collection may have resulted from a deductive approach in which specific questions were developed via a literature review before the gathering of data took place.

4.6 Summary

A qualitative approach to the research study has been emphasised as usefiil, relevant and necessary. Such an approach is seen as part of the requirement to get close to the expenences of middle managers so that the research question is addressed. Thus, there were elements of an ethnographic and case study approach buih in to the research study - for example, longitudinal case sttidy work, comparative case sttidy work, an emphasis upon processes, data gathering via observation, qualitative data analysis and the production of rich description. While some may argue it is inappropriate to generalise from one case, it can be argued that getting very close to managers in one organisation is a means of generalising about processes managers get involved in and about basic organisational activities rather than about 'all organisations' or 'all managers' (Watson 1994). It is a matter of generalising theoretically rather than empirically as Yin (1984) puts it.

The nature of the qualitative approach taken in this study as a craft has been emphasised. Such craft skills have been evident in the description of the research process. For example, qualitative research requires an eye for data gathering opportunities, a flexibility of presentation of self a modification of the research question as certain issues come to light, a continual negotiation of access to the life worlds of insiders. However, this does not mean 'anything goes' as is claimed by some critiques (Silverman 1993: preface). Quahtative research needs to be rigorous, perhaps more so than those approaches which take rigour for granted in their design. While it is difficult to replicate a qualitative research design because of its craft-like nature, in this chapter the intention has been to provide a detailed account of the research process undertaken with a high degree of reflexivity.

4.7 The Empirical Cases

The next four chapters now present the empirical findings that represented the outcome from the methodology described above. Chapters 5 and 6 report upon sfrategic change in the Florence Hospital through two empirical case sttidies or 'strategic subsystems' (Quinn, 1978, 1980, 1982). Both these empirical cases or 'strategic subsystems' illuminate issues raised in the review of literature about the role of the middle manager in strategic change and strategic change more generally. They represent a more inductive part of the research process that contributes to the thesis. In these cases, themes are identified that are then picked up in more detail in the successive cases that are described in chapters 7 and 8.

The case of business planning illustrates the impact of the rational planning element of strategic change upon the role of middle managers. Almost wholly in this case, the emphasis is upon deliberate strategic change. In contrast, marketing activity is much less prescribed for middle managers. Here there is an emphasis upon emergent strategic change. The expectation of the thesis, prior to data gathering, is that upward, as well as downward, influence of middle managers will be much more in evidence in the case of marketing.

Note is also taken of cases of transfer of generic managerial practices from private to the public sector and the extent of central intervention from government, from the health authority or at tmst level, from the board. The empirical case of business planning further illustrates the impact of such central intervention upon strategic change and the role of the middle manager. Generally, in the Florence Hospital, the

content of top-down approaches to strategic change reflects an assumption that generic transfer is appropriate. Where a high degree of central intervention and top-down rational planning or where there is significant generic transfer, the middle manager role is likely to remain one of mainly implementing deliberate strategy. In addition, in the cases of marketing and business planning, it was expected that medical group power would constrain middle managers' attempts to shape health services offered by Florence Hospital.

Chapters 7 and 8 examine the influence of middle managers upon the realisation of human resource strategy. They elaborate upon the themes identified earlier in chapters 5 and 6. Chapter 8 illustrates an enhanced role for middle managers in sfrategic change. In addition, in these latter two chapters, a cross-case analysis is used to identify the necessary conditions for an enhanced role for middle managers (see section 8.4).